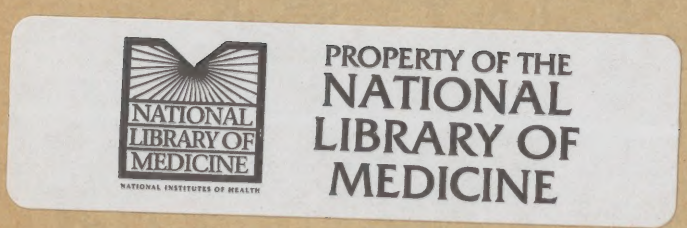
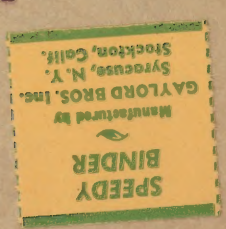
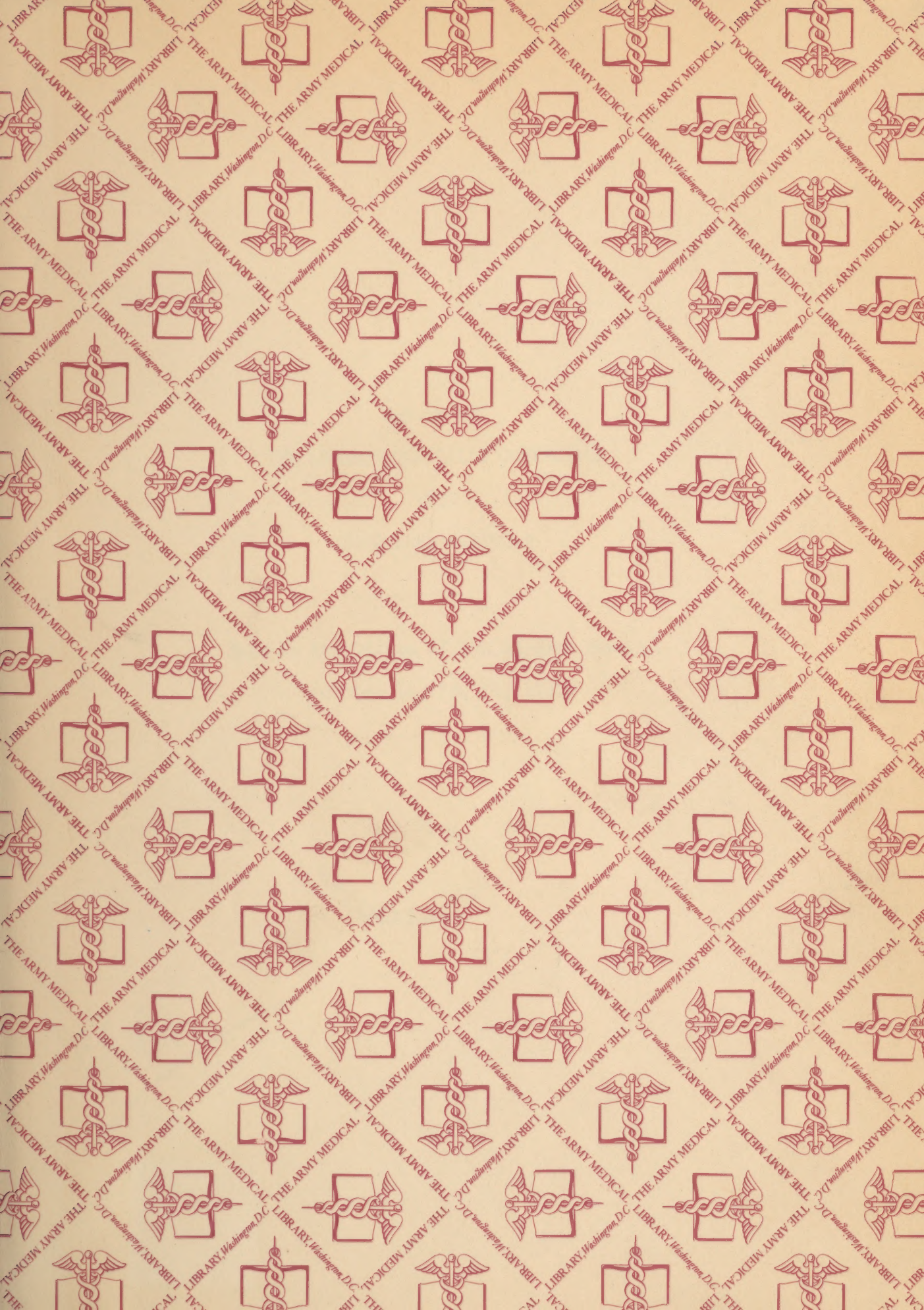
U. S. SURGEON GENERAL'S OFFICE

REPORT OF THE SURGEON GENERAL'S CONFERENCE WITH CORPS AREA SURGEONS



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U.S. Army Surgeon General's Office

Report of

THE SURGEON GENERAL'S CONFERENCE

with

CORPS AREA SURGEONS

Held in the Office of The Surgeon General

October 14, 15, 16, 1940.

The following reports on the conference of Corps Area Surgeons with The Surgeon General held in Washington, October 14, 15, 16, is furnished you as a guide to the deliberations of these meetings and a reference as to the solutions of the many problems presented and the composite opinions of the Corps Surgeons as to present and future policies of The Surgeon General arising as a result of the augmentation of our land force, its mobilization, training and medical care.

A copy of the agenda of the meetings, comprising a digest of questions submitted by each Corps Area Surgeon is furnished herewith followed by a transcription of the stenographic notes taken of the more important discussion and formal replies to specific questions. No attempt has been made to edit this matter as it is felt it is of greater value in its original form in recalling the unreported discussion.

Present:

Major	General	James C.	Magee,	U.S.A. The Surgeon General.
Brigadier	General	Leigh C.	Fairbank,	U.S.A.
Brigadier	General	Albert G.	Love,	U.S.A.
Brigadier	General	Howard McC.	Snyder,	U.S.A.

Colonel	John	F. Reddy,	M.C.	- 1st Corps Area.
Colonel	Frank	W. Weed,	M.C.	- 2nd Corps Area.
Colonel	Henry	C. Pillsbury,	M.C.	- 3rd Corps Area.
Colonel	James	E. Baylis,	M.C.	- 4th Corps Area.
Colonel	Paul	W. Gibson,	M.C.	- 6th Corps Area.
Colonel	Herbert	C. Gibner,	M.C.	- 7th Corps Area.
Colonel	W.	Lee Hart,	M.C.	- 8th Corps Area.
Colonel	Condon	C. McCornack,	M.C.	- 9th Corps Area.

PLANNING AND TRAINING DIVISION

Hospital Construction:

QUESTION: Size and completion of hospitals in 7th C.A. (Camp Robinson, Arkansas; Jefferson Bks., 7th C. A. Tr. Center, Iowa) Hosp. Ft. Riley, Kansas - General Hospital, Ft. Des Moines).

(1) Camp Robinson, Arkansas - 1,000 beds on 1500-bed plan.

(2) Jefferson Barracks - Size not decided.

(3) 7th C. A. Tr. Center - Not definitely decided.

(4) Hosp. Ft. Riley, Kansas - 1,000 beds on 1500-bed plan (less capacity of station hospitals).

(5) General Hospital, Ft. Des Moines: Not discussed.

QUESTION: Hospital construction. Will centers be established on basis of 1,000 bed units or built upon one group of utilities to any size by increase of wards?

COL. BAYLIS: What is the policy or plan for providing central utilities for the various sized hospitals?

COL. HALL: The plans for all hospitals are similar, merely adding more buildings as the hospital increases in size. For each hospital there is a separate mess for duty officers and nurses. Until the hospital goes beyond 500 beds, patients and the detachment use the same mess; after 500 beds there is a separate mess for patients and detachment. After we pass the 1000-bed mark, we have recently put in two patient messes, one in either half of the hospital. Each hospital is heated by a central heating plant. These utilities vary in size according to the size of the hospital. As long as the establishment remains a station hospital, rather than becoming a general hospital, the utilities are furnished from the quartermaster activities of the camp or post; but in laying out our plans for all of our larger hospitals we have used the general hospital plan so that there is a vacant space provided where a fire-fighting establishment could be put up, also a vacant space for the laundry which would be needed after it is a general hospital. In other words, many of our large hospitals which have been built according to our plans could be easily converted into a post within itself, that is, a general hospital.

There will be one laboratory, but in the 1500 and 2000-bed hospitals, as I recall, there are two buildings devoted to surgery.

GEN. MAGEE: We contemplate the following number of beds:

1000 at Devens
1000 at New York
1000 at Charleston
2000 at Atlanta

and will probably ask for 1000 at Benjamin Harrison. We have asked for extra hospital beds in the 9th Corps Area (Vancouver, Santa Barbara, etc.). Existing barracks will be used wherever possible. When additional facilities are needed, the first choice is to build. The last choice is to use the old or existing barracks whenever possible.

Planning:

QUESTION: Reclassification of Hospitals (Letter, S.G.O., July 21, 1937). Equipment for Station Hospitals.

COL. HART: We would like to know about reclassification of the station hospitals due to the increase in population now over that which obtained in 1937 when the hospitals were classified.

COL. TYNG: This office has no definite information upon which we could undertake to classify the hospitals with reference to their supplies. We believe that the respective Corps Surgeons should decide as to the classification and authorize the Commanding Officer of the hospital to submit suitable requisitions for the supply of the reclassification and to notify us in order that we may make any change in classification here. Those requisitions will be honored on the recommendation of the Corps Surgeons.

COL. BAYLIS: What arrangements are being made on the credit allotment to hospitals for supplies?

COL. TYNG: There are these different credits: Credits in personnel, which we have now decentralized to Corps Surgeons. That, I do not believe, requires further amplification. Then, you have standard credits in depots. These, I believe, should now be wiped out and the credits as they exist now should no longer apply, but the Corps Surgeons should submit requisitions irrespective of any credits. We should like to have opinions from Corps Surgeons as to whether or not that is the wisest course to take.

I believe that what we want to put over is this: Credits will no longer exist for the period of the emergency. In other words, we know that a credit system now means delay. We want to avoid delay. Therefore, we know that if we take the hand off these credits there will be some wastage. Of course, there will be some wastage, but wastage is a part of this program; there is no way to avoid it. We believe that you will endeavor to control this within reasonable limits, to prevent overstocking. In this we have the concurrence of the Corps Surgeons.

QUESTION: Ambiguity of instructions to C. S. as to whether they apply to exempted stations.

COL. HART: Is the question of supplies for exempted station in the corps areas our responsibility?

COL. TYNG: From the standpoint of personnel and supply there is no such

thing as an exempted station. Many requisitions are being sent in here. In other words, you will handle everything but general hospitals, their civilian personnel and supplies. You will not handle general hospitals that exist or that are to come into existence.

GEN. MAGEE: Would it not be considered helpful if a policy could be developed whereby Corps Area Commanders could be advised as to the probable strength within their geographical limits?

QUESTION: No plans or instructions as to equipment for Dental Infirmaries and locations not included in ground plans. Hospitalization - recommended it should be under one control (directive on Army and Corps Area Command should determine).

COL. GIBSON: What instructions or plans are contemplated regarding equipment for Dental Infirmaries and locations not included in ground plans?

COL. HALL: The Dental Infirmary was not authorized in the General Mobilization Plan. It has been injected by this office within the last several months. When we first considered it, we began to put them into the hospital group, thinking that that would perhaps be a good location. After discussion with General Fairbank, we discovered that many times the hospital would be too far away from the troops for that to be a good location. Now we are asking for a Dental Infirmary of an appropriate size - 15 to 25 chair - to be put into each troop concentration. The staff has authorized a Central Dental Clinic for each concentration of 10,000 men or over, these to be located by local authority in areas convenient to the troop living quarters. Obviously, you would not want them a mile or two away from troops at the hospital. When we write our requests for a hospital of a certain size, and other medical buildings, we ask for infirmaries, included in which is a Dental Infirmary to be located by local authorities at a convenient place. Recently, at the request of the Dental Service, we asked for one of the DC-2 15-chair units as a part of one of our large hospitals, for two purposes: One, to render dental service to patients in the hospital; two, to act as a Central Dental Laboratory for the Dental Service in that camp.

You will all notice that in the Regimental Infirmaries of various sizes there are from one to two spaces for dentists. These are meant for the use of the dental officers, to set up and make examinations, using field dental equipment. The Dental Service does not intend as a normal procedure to put the higher type of fixed dental equipment in those places. They will be in the Central Dental Clinics. DC-1 is a 25-chair clinic and DC-2 is a 15-chair clinic.

Hospitalization:

COL. HALL: Station hospitals will not be under the tactical commander, and it is thought that they will be a responsibility of the Corps Area Commander.

COL. McCORNACK: I have authority over all non-commissioned officer personnel under the first three grades. So far as other enlisted personnel, it comes under my jurisdiction. So far as sanitation goes, I am supposed to have jurisdiction. So far as supply goes, I do not have any knowledge as to the supplies that are required. I do not know how much expansion is going to occur at the larger stations. I do not know what type of supplies these training schools require. Up to the present there has been no head in the Corps Area of the Air Corps ground force. I understand that the schools, with two exceptions, are to be under one head.

COL. GRANT: As I understand it, the supplies run through the Corps Area as is the case in any other stations. In other words, requisitions go thru you to this office. One exception may have been those civilian schools because that arrangement was set up between my office and this office upstairs. When I furnished a list of the new schools to be opened, approximately 6 or 8 weeks before they were opened, we agreed we would send them certain basic equipment and then their requisitions would come in later.

COL. TYNG: In our attempt to get supplies to these schools that were being opened, we failed to give the Corps Area Surgeons copies of the requisitions for the equipment.

COL. McCORNACK: Do requisitions go through Corps Area Surgeons and then to the Depot, or are they forwarded here?

COL. GRANT: The idea is to put all civilian schools under one center, Moffett Field. I would suggest that supplies for all those schools go through Moffett Field and let Moffett Field put them out, making Moffett Field the one agency responsible for requisitions for all those schools.

QUESTION: Promotes a policy for organization of Medical Department of large camps with Camp Surgeons, also Station Hospital Commanders (Recent letter to The Adjutant General on this subject).

GEN. LOVE: In a recent letter to The Adjutant General it was recommended that in each of the large camps, separate Medical Department overhead be set up distinct and apart from the station hospital and tactical command. That letter is in keeping with the letter which came out from The Adjutant General's Office, setting up a distinction between the Corps Area Service Command overhead and the tactical command, and specifying that the tactical commander would have certain jurisdiction and the Corps Area Commanders would have their uniform Corps Area command, including station hospitals.

We have received no reply relative to setting up the Camps Surgeon's office, but since it is exactly in keeping with the policy of the War Department that has been announced, we have every reason to believe that it will be approved.

(It was recommended that the question be put to vote as to whether or not the Hospital Commander should also be Camp Surgeon in all instances where an establishment of 500 beds or over was maintained. The recommendation was voted upon and disapproved by a majority of members in attendance at the Conference.)

QUESTION: What is the responsibility of Corps in organization of General Hospital within their C. A.?

The Corps Area has no responsibility for General Hospitals. General Hospitals will remain under the Office of The Surgeon General.

QUESTION: Will rank determine who shall act as supervisor of examining teams or will the E.A.D. officer serve regardless of rank?

COL. LULL: Instructions are that the E.A.D. officer would have charge of organization and be the supervisor of the examining team.

GEN. MAGEE: How are civilian physicians to be paid?

COL. TYNG: A $1.50 set up has been made for examining services. Reserve officers will be paid from "Pay of the Army," but civilians will be paid from M&HD funds - $15.00 flat rate per day. The Board provides for 12 professional men and 22 laymen. There is no provision as to how many military men or how many civilians will be on these boards, except that there shall be one military man and 2 non-commissioned officers operating under their warrants; therefore, the balance may be all civilians, professional or laymen.

With reference to your professional group and your lay group on these boards: I would like to have the Corps Surgeons know that we are going to decentralize the funds for this purpose to them. In other words, the entire thing will be theoretically under the Corps Area Commander. You are permitted to obtain your professional and laymen civilians without reference to the local Civil Service Manager, but you will make a report of their employment on Form 44a, required by law, because people who are being paid from Federal appropriations must be recorded, and we want a record in this office and Civil Service must have a record. A letter will be prepared by General Love to that effect.

Civilian clerks will be paid at the rate of $5.00 per day. Without reference to your local Civil Service manager, take them on and make report of their employment. The Surgeon General prefers that this rate of pay would be a uniform rate throughout the United States.

Dental members of the Board will be paid at the rate of $15.00 per day.

With reference to the travel of civilians on these boards, they may be ordered by the Corps Area Commander from place to place, and the Chief of Finance is now setting up a general purpose number under "Travel of the Army" which will include all members of the Board, military and civilian.

QUESTION: Medical care of CCC, a problem with present care at low ebb.

To be hospitalized in civilian hospitals, if Government hospitals not available, as has been done.

QUESTION: Relation of C.S.O. and Air Corps - exempted stations indefinite and in confusion.

Already discussed. (See Question, page 1, Hospital Construction)

QUESTION: Policy on establishment of dispensaries in camps.

COL. HALL: We have several types of infirmaries: I-1 was intended for use as a battalion infirmary. These beds for the battalion section are not intended for patients. Next is I-2, for use as a regimental infirmary. This infirmary is equipped with two beds, for emergency cases awaiting ambulances, etc. These regimental infirmaries are not to be used to hospitalize cases, and no exception is to be made to this policy except where geography makes it necessary. Other types are I-3 and I-4. These are merely small infirmaries, regimental infirmaries modified to allow the flight surgeons' examinations to be conducted. They have no beds. There are only two points that have any beds where hospitalization could be carried on: Arlington Cantonment and Camp Ord.

COL. PILLSBURY: On what Form are quarters cases within a tactical unit entered?

COL. MEEHAN: Form 52 would be used; however Form 52 is not wanted unless the patient goes beyond his regimental infirmary. Form 52 starts at the camp hospital; otherwise the field tag is used.

GEN. LOVE: Would Colonel Meehan explain the new requirements written into the Selective Service law and also induction into the National Guard, that is, the record that is to be kept.

COL. MEEHAN: The record of medical history is to be complete. Instructions regarding the medical history card are being sent out by The Adjutant General. Every man will have a complete medical record while he is in the service. For instance, if a man is marked "quarters" or reports sick to his local infirmary, he will have to have a card and the information will be entered on his record. The responsibility of getting that record will be up to the unit commander. That form will stay with his record all the way through.

QUESTION: Do you want emergency tags for quarters cases at infirmaries? How is a man going to enter a station hospital? By formal or informal transfer?

COL. MEEHAN: By informal transfer. He is sent on a field card and that becomes a transfer card.

QUESTION: In the camp dispensary for a regiment, the only record will be this tag?

COL. MEEHAN: Yes.

GEN. LOVE: Army Regulations 40-1025 covers all information as to sick and wounded. In addition, a field manual will be coming out which will have numerous samples of the way in which these cards will be made out, and every officer will have one of these.

COL. BAYLIS: Do we expect current medical treatments in infirmaries to be furnished from field supplies only, or is there a table of equipment available for supplies that should be on hand in these regimental infirmaries?

COL. TYNG: These supplies may be taken from his chest. Field equipment is to be kept intact at all times. The chest should be immediately replenished upon exhaustion, and the infirmary officer should put in a requisition to the camp medical supply officer for supplies.

QUESTION: How will A.M.A. data be utilized?

GEN. LOVE: As you probably all know, this question was first presented to the American Medical Association by Colonel Dunham at the New York meeting. The plan was discussed in this office before it was presented by Colonel Dunham. It was proposed that the A.M.A. acting through its state and local societies would conduct a survey of the medical profession to determine who in the event of a national emergency, i.e. war, would be willing to volunteer, and of all those who would volunteer which of those would be able to go and which would be unable to go because of physical disability, etc., and of those who were able to go, what particular job they were best qualified to fill. That was presented to the House of Delegates and adopted after unanimous approval, I believe. The A.M.A. set up a Committee on Medical Preparedness, with one representative for each Corps Area, and two for the Second Corps Area. Dr. Fishbein and Dr. West were named, and also the Chairman of the House of Delegates.

As soon as this resolution was passed, the A.M.A. from their headquarters in Chicago, sent out a questionnaire. They are working on an elaborate card system, and I must confess that personally I have been somewhat disappointed that they have had the tendency to centralize the work too much in Chicago. I acted as General Magee's representative in July, and it was the consensus of the Committee that the plan would be carried through as submitted in New York, the reservation being at that time that actual selection of men should be a state society function instead of local but that the A.M.A. should be used as a clearing house, to determine the question of quotas and what Corps Areas and what states should be called upon to furnish personnel.

I represented General Magee again on Sept. 20th, and at this time the question came up again with reference to men who would volunteer service to induction boards. That is an entirely different question from the one originally proposed, since the meeting at that time was largely dominated by the Chicago group. In other words, they would get

the names of the volunteers from various local and state groups, and the Corps Area Surgeons would then call upon the headquarters in Chicago for that information. I told them that I thought this was a mistake, that it would be very much easier for you gentlemen to contact local people, and that it would be very difficult for any one central office to keep thoroughly abreast of the local situation. We are sending out to you shortly a letter setting forth some of the details with regard to the question of specialists and how these specialists can be used to the best advantage. My opinion is that you can probably work better through the local representative.

COL. PILLSBURY: There are a number of very able doctors not in the Reserve Corps. Is there any provision regarding those men?

COL. LULL: At the present time we have gotten The Adjutant General to allot us a certain number of grades -lt. colonels, majors and captains. We have commissioned a few outstanding men in those grades and will commission others in a short time. G-1 has finally consented also to allow us to commission a number of young men and keep them in a pool - not for extensive active duty at once but in a year or two.

GEN. MAGEE: We will have to get some key men. If we cannot meet our needs from men who are now commissioned in the Reserve, we will have to ask the War Department for further legislation as needed.

Training:

QUESTION: Policy of training aviation Medical Examiners.

COL. GRANT: We have two methods of qualification: One is to send the candidates direct to the School of Aviation Medicine, and the other is a correspondence course. Anyone on active duty can take the correspondence course. As far as the school is concerned, there is a course every 6 weeks. At the present time there are 30 enrolled to the class. We have raised that to 37 in the next class, plus 3 or 4 National Guard officers, which will probably amount to about 40 in all. On January 2nd we have new instructions that the classes will be raised to 75 every six weeks. If they have had the correspondence course, we will send them to one of our branch schools for the six weeks' course to complete the training. We hope to have an output beginning January 2nd of 75 every six weeks. We have a lot of flight surgeons who are coming to active duty, but the Corps Areas are not assigning them to Air Corps units and we have great need of them. We have asked the Corps to let us requisition them for men. A list of the flight surgeons we have in every Corps can be furnished to all Corps Area Surgeons.

MILITARY PERSONNEL DIVISION

Commissioned and Reserve:

QUESTION: What is policy as to assignment of R.A.M.O. to Tactical Units?

COL. LULL: It is our policy to assign 5 Regular Army Medical Officers to each battalion and from 7 to 9 to each regiment. They will be assigned by this office. We figure on no regulars with Medical Detachments.

COL. BAYLIS: I thought the purpose of sending some of these youngsters to Carlisle for this "get rich quick" course was to make them available for assignment to Tactical Units.

COL. LULL: But when you send 55 men to Carlisle and then fill up your battalions and regiments which are forming all the time, then take out about 10 volunteers of the class for the Air Corps, that takes care of 1/5 or 1/6 of the class and they make great demands on us to send them back to their original stations--you have very few left.

COL. BAYLIS: What is the order of priority in numbers to be assigned? In other words, what is your first objective and then your ultimate objective?

GEN. LOVE: Major Wakeman, Major Welsh, Colonel McKinney, Captain Page and Colonel Dear were all of the opinion that in so far as possible the detachments and tactical units should have full complement of medical officers.

COL. PILLSBURY: During the period of training in camp they will not have very much to do and that's going to be very hard on morale, because all of them will be Reserve Officers who go in without their consent.

COL. BAYLIS: Why not do it by priority (1-2-3 priority) ? Get this minimum number that I mentioned a while ago so that we will have one officer for each separate unit in the medical battalion, two for overhead, and one for each regimental or battalion detachment. That is a minimum in order to control the men who are assigned.

COL. LULL: Not regulars?

COL. BAYLIS: No, not regulars. Then as a second priority, let's raise the ante a little and put 2 for each Company in each medical battalion, perhaps another with headquarters, then put a regimental surgeon and one medical officer as an assistant, one for each battalion detachment and the final objective a minimum of 15.

COL. McCORNACK: As far as being idle in camp is concerned, I started two medical field service schools in the 9th Corps Area. It is difficult to get enough personnel but nevertheless they are going at it. They are kept busy all day at those schools.

COL. BAYLIS: In connection with the training in general, since it is more or less decentralized or turned over to the tactical units, the question is: How much are we, as Corps Area Surgeons, going to have to do with the assignment?

Of course, that still leaves quite a problem, for some Corps Areas anyhow. All these reserve officers--are they to do nothing but attend the sick? I think they should have some training in addition to that.

GEN. LOVE: I would like to ask Major Wakeman to come down a little later and discuss training.

COL. GIBSON: In the assignment of Regular Army Medical Officers, there will be station changes--who is going to order those? The 5th Division is about to be concentrated at Fort Custer and the units come from the 5th and 6th Corps Areas. That's a local affair for the Corps Area Commander, to delegate so-and-so from the corps area to the division.

COL. LULL: I understand that all those whom we have assigned direct are Regular Officers. A good many of those Reserve Officers are already assigned also. They are assigned to a division; we don't dare assign them to a regiment. The division commander makes those assignments. The Adjutant General directed us to assign them to divisions. We have a few cases in which we can assign more definitely; otherwise we assign to the division. If a division moves, they will be part of the troop movement. We are usually told a short time before the units are sent to these camps. We are advised by the War Department of the troop movement and we are directed to designate usually one medical officer or enlisted man--to order them by name, or station in the case of enlisted men. The names and stations are designated.

COL. BAYLIS: In other words, we end up with the policy that the War Department will assign all Regular Army Officers, generally speaking, and they will be assigned either to the post, camp or station, or to the division.

COL. McCORNACK: I want to take some regulars away from the post and assign them to the division, but I have to request that from the War Department?

COL. LULL: Yes, you make the request and we will ask for the transfer.

QUESTION: Personnel - Will W.D. or C.A. assign Camp Surgeons?

COL. LULL: The War Department will assign camp surgeons. It may be that you Corps Area Surgeons have certain men whom you desire to have assigned as camp surgeons. If you make recommendations to this office we will try to carry them out.

COL. BAYLIS: Generally speaking, it is contemplated making the ranking medical officer the camp surgeon?

COL. LULL: Yes. There is a possibility that I may not be able to give you senior officers and somebody else may become commanding officer of the camp hospital; but we will try to give you senior officers.

GEN. FAIRBANK: The matter comes up about the camp Dental Surgeon. We are going to put in those big camp Dental Clinics, and General Love says the War Department will assign them. We have enough senior Dental Officers--we have checked very carefully--we have enough so that we can spread them around to all these camps. Inasmuch as there is going to be an enormous number of Reserve officers who know nothing of the supply end of it, nor the administration of our camps, it becomes essential that we select with care the men whom we send in there. We will be able to provide the Camp Dental Surgeons in each of the large camps.

COL. BAYLIS: Will the Commanding Officer of the Station Hospital be assigned as such by the War Department? If he is assigned by the War Department, will he stay?

COL. LULL: That I can't answer, because this thing has not been approved about our camp overhead. I can see what Colonel Baylis means, but I don't see how we are going to prevent the senior officer from taking over.

QUESTION: Availability of Reserve Officers Professional Staff supplied from the C.A. and how will any deficiency be supplied?

COL. LULL: The Corps Area is supposed to staff its hospitals from its own personnel in the Corps Area. If this is inadequate, either quantitatively or qualitatively, they will notify this office, and we will make requisitions on other Corps Areas to supply the deficiency. The percentage of Reserve Officers, for instance, in the 4th Corps Area is only 10 per cent of the Medical Reserve Officers in the United States, but the demand in the 4th Corps Area greatly exceeds that percentage. In the Second Corps Area, however, the supply is far greater than the demand.

COL. PILLSBURY: The very class of men we want are the ones that are the hardest to get without breaking up something--faculties of schools, hospital staffs, etc.

COL. BAYLIS: I've thought of a scheme on that--first to agree with them, agree to defer all of them temporarily. Then mention, "I am sure you will agree that the military forces will necessarily have to have adequate medical service", and come back and say, "We have run out; we want at least 25 per cent of your personnel".

COL. LULL: The policy has just come back from G-1, stating it must be remembered that the principle of prime importance now is national defense, and though it is not desired to break up the staffs of any hospitals or medical schools, nevertheless medical reserve officers are obliged to serve when called.

COL. REDDY: I was particularly concerned about Reserve commissions for

a number of men who have had experience in various specialties. Now, they come in and ask for commissions commensurate with their prestige in civil life.

COL. LULL: If you make recommendations to this office for any men you desire, we will have them commissioned in accordance with your wishes, provided they are under 55 years of age. You must also have definite assignments for them. We have to put up a story on why we recommend a commission in advanced grade. There's a sliding scale. First Lieutenants may be commissioned between the ages of 21 and 40, Captains between 28 and 48, Majors between 35 and 55. It's broad enough so that if you have a man who isn't good enough to be a Major, but who might make a good Captain, you can still get him in.

QUESTION: Has or will the policy be changed permitting former Reserve Officers or physicians over 35 years to be commissioned and activated?

COL. BAYLIS: If you are going to open up the question of commissioning Reserve Officers, or rather to continue the question, of commissioning Reserve Officers in the lowest grade (1st Lieutenant), has the policy been changed whereby heretofore they were taken only with the understanding that they would apply for commission together with extended active duty?

COL. LULL: All grades take it with the understanding that they have to go to active duty.

COL. BAYLIS: What is going to happen to interns who are of draft age and of course would like to be hooked up with the Medical Service instead of the draft.

COL. LULL: We have asked approval of G-1 to take these men who are drafted, and who have the other requirements for a Medical Corps commission, and we will commission them in the Medical Department Reserve Corps. We have asked for and received approval to commission interns in the Medical Reserve Corps, and not call them until they have finished their internships.

COL. BAYLIS: They apply only with the prospect of going immediately to extended active duty.

COL. LULL: They will go to active duty as soon as they finish their internships. In other words, they don't want to be drafted.

COL. PILLSBURY: We have had all our interns apply for commission and extended active duty with deferment until the end of the intern year. We looked them up, gave them physical examinations, and then put them on record. They are on record as volunteering for service at the end of their intern year. Then, along about March, the Superintendent will give me a list of those interns who desire to retain associate residencies, and those we defer for an additional year.

COL. BAYLIS: I think that plan is ideal. A large number of these youngsters will come in. The logical time for a Reserve Officer to take his one year's extended active duty is immediately upon completion of his internship. Then he can go on with his civil practice without fear of interruption.

GEN. LOVE: It is again stated that an intern is not eligible for extended active duty, even as a Reserve Officer, until he finishes his internship.

COL. BAYLIS: Regulations do not now prevent the commissioning of any man in the Medical Reserve Corps immediately upon graduation from school, that is, before he has appeared before a Board and secured a license. Is that right?

COL LULL: Provided he applies for commission within one year after his graduation.

COL. TYNG: I think somebody raised the question, talking about men who have complied with all legal requirements and the requirements of Army Regulations for commission, and then the long delay which occurs before they get their commissions. Whenever you have men of this type whom you would like to place immediately to keep them satisfied, without reference to Civil Service, but under Rule A IV-IX and then reporting them on Form 4-A, you may place them on duty. Report to this office and we will pay their salaries. I am trying to put over the fact that you can place them wherever you desire. That is a status that would permit us to go without reference to Civil Service. They are civilian employees. I am quoting a rule of the Civil Service. This is for a period of time that will not exceed the sum of $540 in any one year. May I go a little further and state that if there seems to be some delay, or if you have a man who is valuable and yet is physically disqualified, you may urge him to obtain a Civil Service status and you can put him on a commensurate rate of pay under Civil Service rules.

COL. PILLSBURY: Take an intern, we have fixed up a commission for him, we go through the necessary procedure, he is unable to pass the physical examination required for officers but does meet the physical requirements for drafted men. What happens to him? We have quite a few of those, with such defects as color-blindness, etc.

COL. HILLMAN: I would waive the color-blindness and let them be commissioned. In a case of defective hearing, I think that if a man does qualify for commission I would recommend waiver.

COL. BAYLIS: I have a question on these physical requirements. Suppose a National Guard Officer is being examined for induction in the service. He is 45 years of age and he reads 20/100 which is only corrected to 20/50. He doesn't meet requirements.

COL. HILLMAN: No, he doesn't meet requirements, but if he is very acceptable otherwise he may be waived. I would approve the commission of these men up to the procurement objective.

QUESTION: Will resident physicians be deferred?

GEN. LOVE: No, they will not be deferred.

COL. PILLSBURY: Then if a young man applies for active duty, he thereby gives up all hope of becoming a resident?

GEN. LOVE: I had a conference with several of the leading doctors of the country. They agreed in toto that residents should not be deferred.

COL. PILLSBURY: What I am getting at is this. Suppose you are running a hospital and you pick out 8, 10 or 12 residents from your interns and you make that selection along about March. If this thing goes through and everybody physically fit is picked to serve, you will lose all of those residents. Give them a chance to build up their strength.

COL. LULL: I think that will have to be arranged with the local Corps Area Surgeon.

COL. PILLSBURY: Well, can I do that? We need, say, 15 doctors; some residents who have no dependents are included in this group, the rest of them are people who have asked for deferment because of dependents. Have I got the right to defer these residents and take these other people against their will?

GEN. LOVE: I discussed that with Dr. Cutler and he agreed without any reservation that residents should serve.

QUESTION: What is policy on use of M.O. of tactical units (N.G. and R.A.) in Service Command Hospitals?

COL. WEED: We have the 44th National Guard Division over at Camp Dix. We had no medical personnel there and it is obvious that we have to use the medical personnel of the medical regiment of the division. I might add that I had a committee come to my office and try to get me to promise that we would let them go into the hospital and do professional work throughout the time they were in camp and I told them I could not do that; I could use them only temporarily. I got the Corps Area Commander to direct the division to supply on call of the camp commander such personnel as was necessary, both enlisted and commissioned.

COL. LULL: G-1 said that the sick would be taken care of and if there was not enough overhead allowed for the 224,000 National Guard they would furnish medical personnel. We have to utilize these people together with civilians until we get enough men from the draft.

COL. BAYLIS: I have a little different angle and this is how it came up. A Major in the National Guard Medical Corps belongs to the State Health Department of Mississippi and is supposed to be an exceptionally well qualified sanitary inspector. Can we definitely take him away from his unit which is due to go to Blanding, we'll say, and assign him to Camp Shelby as sanitary inspector? Can we use him in that capacity full time

after he gets to Camp Blanding--let him be designated as part of the camp overhead if he is assigned right now to that division?

ANSWER: We can not do it now but we look forward to the time when we can do it.

COL. LULL: We have taken them out of their divisions and put them elsewhere. They can be used anywhere within the station but they can't be called for duty in a station hospital.

COL. PILLSBURY: I have a question I would like to ask on those interns. Do you recognize a second year intern as well as a first year?

GEN. LOVE: The War Department announced that they would be exempt only for the first year and you must not call them to duty until they have completed that year. In so far as practical, however, you will defer them until they have completed their second year. One is directive and the other is discretionary.

QUESTION: Will affiliated units be used to man General and Station Hospitals of comparable size?

COL. LULL: No, affiliated units will not be called as such.

COL. McCORNACK: I have had several members of affiliated units who really objected to being called at this time because they are members of those units. I told them that we will call them out now and if and when their unit is ordered out, I will try to assign them to it.

COL. LULL: We were going to commission some of these older men in affiliated units and put them on active duty. Later we found out that we would get into trouble. If a man is a Captain in the Reserve Corps and gets a commission as a Lt. Colonel in an affiliated unit, he must be called as a Captain in the Reserve.

GEN. MAGEE: We can't excuse a reserve man just because of that.

COL. PILLSBURY: We had a number of discussions at the John Hopkins Unit. Practically every otherwise eligible intern has volunteered for service at the end of the intern year but they wish to know if some arrangement can be made whereby, if selected, they can carry on their medical education as a resident, to be commissioned at some later date without deferment as a resident.

GEN. MAGEE: We have had a great deal of trouble getting deferment of either medical students or first year interns--so much trouble that the President is giving the matter his personal attention. I am quite sure that deferment beyond one year internship will not be permitted. In the light of that we all knew it was useless to ask for deferment of residents. After all there are only 4,000 of these men and if one man in twenty is caught in the draft that means only about 200 will be called out. This won't disrupt any hospital. I think we should arrange

to let them continue that same work in some of our larger general hospitals and get credit for it; but even if that couldn't be arranged the most it could mean to a man is one year away from his residence.

COL. PILLSBURY: Looking at it from the procurement point of view, we can get these young men now only if they volunteer for service. If we can guarantee to them that their future medical education will be taken care of should they be selected, then practically all of them will volunteer for service at the end of their intern year.

QUESTION: May Reserve Officers of an affiliated unit be ordered to active duty with consent pending active duty assignment of their sponsored unit?

COL. LULL: As soon as they are commissioned. They are under your jurisdiction until the unit is formed and transferred here.

COL. BAYLIS: Those men who came in and got commissions purely on the basis of the affiliated unit association cannot be ordered to active duty now.

QUESTION: National Guard Units are reporting with the Medical Department personnel under strength and will they be brought to strength before departure from the C.A., and if so, from what source?

COL. LULL: They are allowed to continue recruiting and there is no reason why the personnel should not be brought up to authorized strength.

COL. WICKERT: I think I can clarify that because this thing came up in the 1st Corps Area and I took it up with the Adjutant General. He said most of the National Guard Units are under the impression that they have to discontinue recruiting but as a matter of fact they can recruit and they are recruiting. They should bring their units virtually up to strength and make all their promotions as far as enlisted men are concerned within their own units and within the allotment of authorized grades and ratings. Any deficiencies will be filled up with inductees.

COL. REDDY: By the time they are inducted, before we get our big increase, it is going to be very difficult to secure enough officer personnel.

QUESTION: Can we secure officer personnel within thirty days time?

GEN. MAGEE: An officer couldn't go through the mill and be federally recognized within thirty days.

The selectees are being brought in to fill up the Regular Army and the National Guard Units. As I understand it, this National Guard movement is for one year. The inductees are being brought in the National Guard for one year.

QUESTION: What latitude may be assumed in selection of officers qualified for the position in the matter of rank? How tight do t/o hold?

COL. PILLSBURY: The tables or organization call for a station hospital with so many Colonels, Lt. Colonels, Majors, Captains and Lieutenants. You find that you have one Captain who could be used in a position which, according to the t/o, should be filled by a higher ranking officer. Can you assign him to that position?

GEN. MAGEE: Those same t/o say that if conditions arise that the only man you have to fill a position is not of the rank specified, you may assign him.

QUESTION: Policy toward activation in Reserve Commission and retention in C.S. office of one N.C.O.

COL. PILLSBURY: I have a Master Sergeant who has a reserve commission as a Captain.

COL. LULL: The War Department directive said that without cogent reasons an enlisted man would not be commissioned and kept at the same station. We have recommended exceptions in the Corps Surgeon's office and in some large general hospitals. We have allowed them to keep one by putting up a good story that he replaces an officer and has lived off the post and has not associated with the enlisted personnel. This applies especially to men commissioned in the sanitary corps.

COL. McCORNACK: I have been ordering some to active duty within the Corps Area service command. They claimed we had full authority to do so.

GEN. MAGEE: I think it would be well if you agreed to refer all Medical Administrative and Sanitary Corps assignments to this office.

QUESTION: If interns are not deferred, can they earn credit while on active duty(answer appears to be, if they are serving in an accredited hospital, "yes", if not, "no").

ANSWERED BY PREVIOUS DISCUSSION.

QUESTION: Deferment policy toward Reserve Officers assigned to affiliated units or essential teachers in professional schools. Also interns and residents.

ANSWERED BY PREVIOUS DISCUSSION.

QUESTION: Personnel - Part-time use of civilian physicians for "Army Hospitals, Camps, and Reception Centers" being established by Civil Service. How will drafted doctors, dentists and veterinarians be used? Policy on calling to E.A.D. Medical Department Reservists of field grade.

COL. GIBSON: We have hundreds of applications as a result of advertisements put out by the district managers of the Civil Service requesting

applications from doctors for duty at Army hospitals, camps and reception centers.

COL. TYNG: At the time we got authority to raise the Army to 375,000 men, it meant a 95,000 man increase. The War Department would not permit the Medical Department to expand but they did give me authority to employ 657 physicians. What I attempted to do, without success, was to have Civil Service permit me to take those physicians in without reference to Civil Service Registers. They would not do that, so they held an examination. In preparing for that examination, through the Journal of the American Medical Association and through the district managers, they gave the impression that we were desperately in need of doctors. Now what they have done is this: They have held this examination and, as a result, there are available to you gentlemen, for this fiscal year only, for permanent employment, such physicians as are on their lists and these you may make free use of to supplement your increment of medical and surgical services pending your acquisition of reserve officers. They are full time for such time as you need them. These people must be obtained from your local Civil Service Boards. They are in every respect Civil Service employees, and I would like to have them disassociated in your minds from emergency doctors that you need for a period of less than 60 days which you can go out and get for yourself, reporting them under this A IV-IX which I quoted. We will set up funds upon notification of employment.

COL. REDDY: What will they be paid?

COL. TYNG: They will be paid whatever you wish to pay them, from the very lowest--$2,000.00 up to $4,800.00, or even $6,000.00. If you get a man who is rated on the register at $2000 a year and you find he is worth more you may reallocate.

COL. LULL: If caught in the draft we plan to have them put in for commission right away.

We have expressed a wish to keep the calling of reserve officers down to company grades. Each case can be judged on its own merits.

QUESTION: Can non-affiliated reserve units be called out and what responsibility has C.A. toward affiliated units?

COL. LULL: Affiliated units are under our control (Surgeon General's Office). No officers are to be called.

QUESTION: Has "Mobilization Assignment" any status?

COL. LULL: Very little if any.

QUESTION: What assignment of Regular M.O. to larger hospitals?

COL. LULL: It is the tentative decision to furnish General Hospitals

with the Chief of both services (surgical and medical), Commanding Officer, and Executive Officer. The War Department has sent out a set-up by grades to each Corps Area.

QUESTION: When will M.A.C. Reserve be available?

ANSWER: This information has already been made available.

QUESTION: Will N.G.M.O. remain with tactical organization throughout years of training?

ANSWER: This has already been discussed.

Enlisted:

QUESTION: Enlisted Personnel - How will Enlisted Medical Department be supplied pending 3 months training and non-availability of inductees subsequently assigned to Medical Department?

COL. WICKERT: There are no more men available to the Medical Department for assignment, but the Corps Surgeons are probably familiar with the radiogram from the A.G.O. authorizing over-recruiting in units beyond their authorized Table of Organization and up to their war-time Table of Organization strength. Since so many Medical Department men are in detachments for which no Table of Organization exists, Medical Department and Quartermaster detachments which have no Table of Organization for war strength are to be recruited to 15% over their present strength, which is all we can do until the inductees become available. All Medical detachments are authorized to be recruited to 15% beyond their present authorized strength. Of course the whole problem goes back to last December, when in the 17,000 Executive Order increase, the Medical Department did not get a single man for hospitalization overhead. We got 1600, but all men were obligated to the tactical units.

Bringing in the National Guard did not give us one man, not a grade or rating, to carry on any of the hospitalization. Making a comparison to our present authorized strength of 24,000, 350,000 National Guard will have to carry the same overhead as 350,000 Regular Army.

COL. TYNG: (Displaying charts)

In the small chart on the left, the red represents the beds in existence, which is roughly 18,750. The orange represents the Medical Department soldiers authorized for the current Regular Army, which is 18,187. The large column on the right represents in red about what the bed expansion is going to amount to, which is about 70,000, as against 18,000 on the left. The orange chart on the right represents the same soldiers in the Regular Army at the present time, showing no increase whatever. Referring to the bars on the left, at the top of the orange is a little blue strip; that is the regular civilian field employees, about 1640. The top right green bar represents those men that Colonel Wickert referred to who will become available, the inductees, ranging about 24,000 men.

The brown bar represents what we must have to provide hospitalization, in the way of civilian employees. We have obtained the money for about 28,000, these to be distributed throughout the Army for the care of these beds. This amounts to about 18,000 Regular Army enlisted men for hospitals, 1640 regular civilian employees, and 28,000 temporary employees to be provided when conscription is underway. As the requirements of the Corps Areas change, this office should be notified.

CHART

Basis for additional civilian employees

Army of 375,000: 18,750 beds required.
18,187 Medical Department enlisted men in hospitals.
1,640 Regular civilian employees.

Army of 1,418,000:
18,187 Medical Department enlisted men in hospitals.
1,640 Regular civilian employees.
28,516 Additional civilian employees.
23,000- 25,000 Inductees for training.

The second chart is a recapitulation of the positions of which we notified you on September 12. If you need more employees at this time, do not hesitate to put them on, or wait until later if you do not need them now.

It is The Surgeon General's thought in presenting this to Congress to obtain the money for these employees that our best program of training would be to take these inductees and train them in the technical matters of the hospital. They are not to be used for menial tasks, but we are to fall back on the civilian employees for such work and devote the technical training to these inductees.

GEN. SNYDER: Do you contemplate rotating the use of the enlisted personnel of the National Guard in Medical Regiments, to assist in the care of the sick at the camp hospitals?

COL. WICKERT: G-1 is going to make available to the Medical Department 22,000 for overhead, which includes Corps Area Surgeons and War Department overhead. The War Department overhead on November 18 will be 1030. This is a relatively small portion of our requirements; however, since the first 400,000 men will not be available before March, everybody is taking a proportionate cut on their requirements.

GEN. MAGEE: When will the first inductees be received?

COL. WICKERT: The only group on which I have definite information as to grades and ratings is the 1030 which will be available on November 18. There will be another small increment on December 2. The inductees that are going to be made available will have their grades and ratings on the same basis as at present. For tactical units, they will be according to Tables of Organization. We will get them in stages on the basis of the numbers that are made available.

COL. MC CORNACK: I would like to know if we have authority to recruit our strength 15% over our present Corps Area allotment?

COL. WICKERT: The Corps Area allotment can be increased by 15%. There is only one restriction, that is, the question of being able to house and equip these men, which is the limiting factor. The present allotment applies only to units within divisions which are already in existence.

I have just been informed by G-1 that all grades and ratings incident to these inductees for Corps Area Service Commands have been or will be allotted to the Corps Commander without any classification. He gets so many for his entire service command, and he will make such sub-allotments and distribution as he sees fit. They will be set up as so many grades and ratings. The average pay of Medical Department enlisted men is $441.00. There has to be deducted from that $252.00, which is base pay as a grade 7, and the difference represents the money you can use for grades and ratings. Grades and ratings do not have to be distributed to Selective Service men. We are talking only about detachments, and not units. There are no increased grades and ratings to the Regular Army, as such, over and above their regular allotment. There is a redistribution of grades and ratings to adjust some discrepancies, which will give about every Corps Surgeon an increase in their grades and ratings, but there will not be any appropriated on the basis of the 15% recruited. The allotment is made up on the basis of number of men the War Department is making available to the various Corps Areas for the Corps Area Service Command. This is in addition to existing grades and ratings, and is allotted by virtue of getting additional men, that is, the inductees.

GEN. LOVE: We would like to make a statement regarding civilian and enlisted personnel. We received no enlisted professional overhead for the National Guard but they promised to give us enough to make up this deficit from the Selective Service men. I think we get approximately 50,000 enlisted men to cover this deficit, with an additional 29,000 civilians. G-1 talked with us several times, asking if we could not reduce the 50,000 men by the 29,000 civilians. We want the civilians to cover the gap to serve the Professional Service, and then we can get the enlisted men in training. It is essential that we have this full quota of enlisted men. If we depend on civilians we will not be much further along than now. They agreed to give us our full quota of enlisted men and 29,000 civilians, with the understanding that as soon as convenient and possible we

would make as much of a reduction in our civilian personnel as possible. They are to be on menial work and highly technical positions which enlisted men cannot be trained to take over.

We have been working with the Red Cross and they have advertised for technicians and enrolled them. We are still having some difficulty with the Civil Service in allowing us to take these people on in civilian status. As for the Red Cross technicians, those who are subject to the draft will be enlisted; others will be brought in as civilians, at $1620 and $1440.

COL. PILLSBURY: What about those over the draft age?

GEN. LOVE: Civil Service has said that if the Secretary of War will declare an emergency, they can be brought in and will go on Civil Service status on being reported.

COL. PILLSBURY: We are going to be operating the station hospitals largely with enlisted men from the National Guard during this hiatus. Is it the policy that as soon as the draft comes in we can replace these men?

GEN. LOVE: We recommend that the same policy be used with the National Guard as with other enlisted men: at least one-third of them in the hospital for technical training.

QUESTION: Three clerks are required by examining teams at induction stations. What is the source?

We have been authorized to employ them at the rate of $5.00 per day, and these are temporary clerks who do not have to be taken from Civil Service.

QUESTION: Who provides enlisted assistants for examining teams?

This is a Corps Area function. A directive is being prepared on this matter.

PROFESSIONAL SERVICE DIVISION

QUESTION: Physical examinations of Reserve Officers for E.A.D. Recommended they report to nearest Army Hospital and then proceed to station wanted if found physically fit.

GEN. SNYDER: A question comes to us with reference to preliminary examination of officers. There have been many embarrassing situations, in which cases were forwarded to the War Department with reference to a number of officers who had been disqualified on preliminary examination and discharged from the service; and again on reexamination by the second examining board were found qualified and the Corps Area Surgeons recommended that they be reinstated. After some discussion the question has arisen as

to whether it would not be better to discontinue this preliminary examination and have all officers meet the requirements of only one physical examination, and that at their station of concentration or training, where facilities are available for proper examination.

GEN. MAGEE: That is a question which has been discussed for one or two years.

COL. McCORNACK: We of the 9th Corps Area have recommended time after time that the man be given a period of time to correct a disqualifying defect, if it is remediable, and then be returned to active duty.

GEN. SNYDER: G-1 makes the recommendation that only one type of Board be used in examining officers, and the preliminary examining boards should be dispensed with. I took the position that only one final type of board should be used for examinations before the present method was adopted and put in the regulations, but this course was not followed. We want to get The Surgeon General's opinion of the plan to do away with the preliminary examinations.

COL. HILLMAN: This office would be delighted if we could have one final type examination and have it over with. This preliminary examination is as much trouble to us as to anybody else. Sometimes when a Reserve Officer has been given a preliminary examination and ordered somewhere on active duty, upon being given the final examination it may be found that he has a disqualifying defect that would have prevented his coming to active duty. In other words, it is one of those things which causes disagreements, and obviously causes much difficulty and calls for more and more correspondence to dispose of the case. We would like very much to have only one examination; but it was under pressure from the National Guard Bureau that the present system was established.

COL. WHITE: When we drafted the instructions which went out on September 4th, the idea in having an examination at home stations was to eliminate the physically unfit before they left home and before they arrived at the station; but it did not work out that way. Now they take the preliminary examination at home, the papers go to the Corps Area, and before they are acted on the man has left home and gone to camp, whence he may get orders to be relieved from duty on the same day of getting orders to report for another examination. It has not gotten rid of the physically unfit officers on the preliminary examinations as we thought it would, and a great deal of suspicion has arisen which I think we can largely overcome if we do away with the preliminary examination of officers at home.

With reference to preliminary examination of a National Guard officer, he is in the Federal Service and on a pay status. It seems to me that we could cut out the preliminary examination of commissioned personnel at home and give one final type of examination where facilities are available. When a Reserve Officer has a hernia and has the hernia repaired, he can get E.A.D. If we relieve a man from duty for a remedial defect and he can get it corrected, he may be returned to ac-

tive duty. This does not hold for National Guard officers.

COL. HART: We should try to get the War Department directive removed requiring preliminary examination, because it gives the man too much leeway for evasion. It has been the policy of the 8th Corps Area to order the man to the station where he can get his final examination before ordering him to active duty. If he is found physically fit, he is passed right along.

GEN. LOVE: This office will make recommendation to The Adjutant General that the preliminary examination be dispensed with for all officers ordered to active duty, and that the man be sent to the nearest military station for final examination, where the proper facilities are available for the examination.

QUESTION: Where will final examination of enrollees for service be made? Induction Stations or Reception Centers?

At the Induction Stations.

QUESTION: Where will X-ray examinations of Inductees be made? Reception Centers?

COL. HILLMAN: We have been unable to set up any practicable scheme for X-ray examination of all inductees because of the requirements of the War Department that they be examined and their status determined on the day that they appear before the Induction Board. Because of that limit of one day we have felt that it was impractical to conduct X-ray examinations except for those whom the chest examiner found to have some indication of tuberculosis. These cases requiring X-ray examination will probably have to be held over to the next day, by which time the X-ray can be made and paid for from Medical Department funds. Colonel Tyng has prepared a directive covering that particular point.

COL. TYNG: I have put nothing into the recommendation to Colonel Love as to how much we will pay for these X-rays. That has to be settled. We were advised by the Association of Roentgenologists that $5.00 should be the maximum for a chest plate. We told you that the pay of civilian laymen on these boards would be $5.00 regardless of the type of duty they were performing. If some of the Corps Areas could arrange to have these X-rays made for one or two dollars each, we could get an average of $5.00.

COL. HILLMAN: X-ray examinations are to be given at the request of the chest examiner on the Board. We hope to have this X-ray examination a part of the routine examination in the future on all applicants for induction, but that is not possible now because of lack of facilities. For a year or more the Surgeon General's office has studied the matter of rapid chest X-ray, with a view to adopting, if there is such a thing, a fairly inexpensive method which can be used rapidly and applied to all men coming into the service. We have studied various methods. First, straight out-and-out X-ray, using a 14x17 plate. We have studied the

method advanced by the Powers X-Ray Products Corporation of New York, which uses a paper film in 150-foot rolls, which has the element of speed so far as taking the pictures is concerned. But it takes two or three days to get this film sent back to the central developing place where they have the equipment to develop it, so we do not get the net result rapidly.

Another scheme has been developed in which you have a man stand in front of a fluroscopic screen with a camera on the opposite side which takes a picture of what appears on the screen.

There are two other methods, one in which the final picture is reduced to 4x5 prints, and another using 35 mm photographic film. The 35 mm photographic film does not get enough detail and we have discarded that. We have adopted the policy of 4x5 reproductions and have ordered 45 sets of this equipment and will probably order around 55 more, making a total of 100 at a cost of $250,000. In the spring, if we can do so, we hope to have X-rays of everybody, using this 4x5 reproduction, and have them studied and filed with the individual's record. This is to be done by the Induction Boards, and is only a hope for the future. It cannot be done now.

All methods seem to require that men be held over 24 hours. G-1 thought that this could not be done. Therefore, in order to make this service available for those who seemed to need it, we have arranged to provide that civilian facilities may be used, or Army facilities, or other Federal hospital facilities. Arrangements will be made to utilize the facilities to get X-rays of chest in that limited number. With that in view, we have had The Adjutant General address letters to the Veteran's Administration, Navy, U. S. Public Health Service, and the Bureau of Indian Affairs, asking them to cooperate in this and make their facilities available for X-ray and other examinations, such as laboratory examinations, and telling them that bills for same may be submitted to this office on Form 1080 series.

GEN. LOVE: Regarding the question of whether during the contemplated induction it will be feasible to have the regular large X-ray prints made for every man who is inducted, Colonel Tyng will distribute the X-ray films to the various Induction Boards and the civilian facilities in that community may be used to make the exposures and develop the prints.

COL. REDDY: The State of Massachusetts wants to make the pictures of all the men, using its own personnel, but wants to know if they can be furnished the films. New Hampshire will do this without any cost to the Government at all.

COL. TYNG: I would suggest that where it is feasible, in areas of dense population, if some of the states would like to participate in this thing, we give them full authority to make all such arrangements as they desire and tell them to call on The Surgeon General for X-ray films and any additional money that they might need.

STATEMENT: Recommendation that physical examination should be preliminary type only unless it suggests a "final type" for three months active duty or less. (Law dictates present provision by making full retirement privilege applicable after 30 days.)

COL. HILLMAN: I would be willing to recommend a 60-day limit, instead of the 30-day limit. We would like examinations of final type to be good for 60 days.

STATEMENT: Preliminary physical examination in case of compulsory activation should be eliminated.

This point answered in previous discussion.

STATEMENT: Large number of physical examinations consuming great deal of time at all stations.

COL. HILLMAN: That there are a large number of physical examinations is true, but we feel that nothing is much more important than that these final physical examinations be performed really well. It was decided that no preliminary examination would be made on officers coming to duty in Washington, but only the final type of examination would be given.

COL. GIBNER: The question of requirement of one Medical officer on examining boards for final examinations presents a difficulty that is going to become worse and worse.

COL. HILLMAN: We all agree as to the importance of these examinations, and they should not be done with Reserve Officers serving in place of Regular Army Officers.

STATEMENT: Physical examination N.G. - Delayed examinations due to sickness. Necessity of convening new boards. Cost of making examinations and delay beyond 30 days. Suggested commanding officer report immediately all cases not examined to permit of plans to accomplish same at an early date.

COL. WEED: With reference to cases where men are unable to report at the Induction Station, do we have to organize boards and send them out all over the Corps Area? AR 130-10 does not require the Board to examine anyone not present for examination.

GEN. SNYDER: Are the local boards to remain in organization until they have concluded their examinations?

COL. McCORNACK: That is impossible, since the boards are made up of National Guard and Reserve officers.

COL. WEED: Some disposition or decision must be made within 30 days.

COL. McCORNACK: If an enlisted man is not examined within 30 days and illness resulted in making him unfit for military service, he can be re-

leased on C.D.D. without charge to the service.

COL. GIBNER: What about discharge from the service of National Guard men who do not present themselves for examination at the proper time?

GEN. SNYDER: This is contrary to Mobilization Regulations. When induction is ordered by the President, the man is in the service whether he comes to duty or not.

GEN. LOVE: We might adopt the policy that where a man is physically unfit he be discharged and sent to the nearest military station of his home unit as soon as he is able to travel. For those who are clearly physically unfit, their discharge should be recommended. Those who may recover should be ordered to their proper station for examination after their recovery. In other words, if the illness is of such nature that he is likely to recover in a reasonable time he should be given the examination after his recovery.

GEN. SNYDER: Wherever possible, at the earliest practicable date he will be transferred from the civilian hospital to the nearest Army facility.

GEN. LOVE: Colonel Hillman will make a recommendation to the War Department on this matter of policy. For National Guard soldiers, enlisted men or officers, who are unable to appear for examination and who are found upon examination to be permanently incapacitated, discharge should be recommended and certificate of disability issued. Those who are suffering from temporary illnesses from which they may eventually recover will, upon termination of their illness, be ordered to the nearest Army station for examination and then sent to join their organization after completion of the examination.

COL. McCORNACK: The regulation on disqualification of men with well-fitting dental plates is too rigid and should be modified. MR 1-9 bars enlisted personnel with dental plates.

(A general discussion was held concerning disqualifying physical defects, and degrees to which they might be waived, in the matter of eye, ear, and dental defects, and abdominal disorders.)

COL. HILLMAN: Soldiers with peptic ulcer should be discharged, and it is recommended that all people with a history of peptic ulcer should not be accepted. In the matter of hernia, people should have a six months' period to see the results of the operation before being put on active duty. It does not seem expedient at the present to change our physical standards pertaining to eye and dental requirements, so far as appointment in the Reserve is concerned.

STATEMENT: Disease prevention in inductees. Stations and Reception Centers and X-ray of chest by states - New York and possibly New Jersey.

COL. HILLMAN: So far as I know, there is only arrangement for hospitalization of men after they become inducted.

COL. PILLSBURY: This is in the regulation; the man is sent to the nearest civilian hospital and the bill is paid by the Government.

COL. WEED: If disease is contracted during induction, the man is sent to the nearest Federal, Army, or civilian hospital. The applicant does not become the responsibility of the Medical Department until after he is sworn in. If he has not taken the oath, he is turned over to the city or state authorities.

GEN. LOVE: He is not actually in the service until he has been sworn in.

GEN. MAGEE: I see that we have voted down the idea of chest X-ray at Induction Boards.

The states of New York, New Jersey, New Hampshire, Massachusetts, and Wisconsin have all offered to take X-rays. We are very anxious to get pictures of the first group of men before the cameras for the 4x5 plates are available on December 1. We want X-rays taken wherever possible. We will provide the film and they will contribute the use of machines and the men operating them will have the same $15.00 per day rate as the other doctors. I wish you would all give thought to it, because I think it is of first importance to have a finding on every man if it is at all possible.

STATEMENT: Medical supplies and prophylatic units for Induction Stations.

COL. WEED: We must provide facilities for men for prophylaxis after exposure. I suggest that Colonel Tyng should see that each of these boards is supplied with M&S Chest and V.P. units.

COL. TYNG: If these boards were to each have the chests you speak of, it would make quite a packing problem at the expense of some very necessary packing that has to be done to assemble hospitals. We will do it if that is the consensus of opinion of the Surgeons. For medical attendance, you have funds with which to hire physicians. As far as the prophylactic unit is concerned, we can supply everyone as many as they need. We are going to give you everything that you desire, and that you require, if we have sufficient notice. My recommendation would be that in all probability you will not require the chests where you have facilities in the cities in which you can get prescriptions and medicines as required.

QUESTION: Policy on X-rays of chest and Wassermann Tests. Will routine blood typing be done?

COL. HILLMAN: In the first place, the syphilis-consciousness of the country is becoming such that we feel that all military personnel will have to be given a survey to determine the amount of syphilis. It is thought that before the year is over, request will be made that all military personnel have serological or precipitation tests first, confirmed

by Wassermann test. The Public Health Service gave consideration to the matter and offered their cooperation toward getting serological tests on all those who would volunteer for tests on Registration Day. They are very enthusiastic but it appears highly impracticable to get so many tests on the same day. With regard to the 500,000 people who will come before the induction boards, the Public Health Service decided that since they could not get the serological tests on each registrant on registration day, they would like to have them on all men examined by the local boards. This was put before the Osborn Committee, advisors to the President on Selective Service, and it was agreed by the Osborne Committee upon presentation of the situation by the Public Health Service that they could and would be glad to have serological tests done by the local boards so that Volume 4, which has not yet come out, will come out with instructions to the local boards to do serological tests on all registrants. If the test is positive, it will be confirmed by a second test before the man is deemed syphilitic. Thus, this information would be available before he comes to the Induction Board.

The Surgeon General has felt that we are not justified in taking these 20,000 or 30,000 syphilitics, who probably will require treatment, and that they should be rejected, once that information is available to you. Such a recommendation has been made to The Adjutant General. I take it that they are going to issue that as a Circular further modifying MR 1-9, so that no venereals will be taken, including syphilitics. As soon as we get this information from the War Department, it will be transmitted to you in order that you may be able to identify these cases.

GEN. MAGEE: The Army will not be concerned with serological tests on these people. It will be done by the Public Health Service.

COL. HILLMAN: As soon as this information is received, a directive will be issued and the information passed on to the Reception Centers to show that the applicant has had a serological test. Serological tests should be made on all those in the service now if it is practicable to do so.

COL. PILLSBURY: Will routine blood typing be done?

COL. HILLMAN: That hinges on the number of laboratory men we have to do it. Do not take blood for typing until you get further instructions.

QUESTION: Disposition of mental cases.

COL. HILLMAN: We have an acute situation at Walter Reed, which has 200 closed ward patients.

GEN. MAGEE: We hope that as construction goes on we will be able to remove some of that load.

COL. HILLMAN: Hospitals of over 500 beds should take care of their own and dispose of their own N.P. cases.

GEN. MAGEE: If each Corps Area Surgeon will take every step he can toward disposing of cases in his own Corps Area it will help a great deal.

QUESTION: Information is desired on the Laboratory Service.

COL. BAYLIS: We wish to inquire about establishing Corps Area laboratories to do certain general laboratory work, letting only the routine laboratory work be done at the various posts, camps and stations.

COL. SIMMONS: The epidemiological and sanitary work could be concentrated in one place. Every hospital above 100 beds should be self-sufficient as far as diagnostic work is concerned. The more difficult procedures in small hospitals should be sent to the larger laboratories. I think that sanitary examination of food, water, and milk, and collection of specimens for any type of epidemiologicals, and the excess serological tests from the small places could be centralized in that way and save in material and specialized type of people needed for this work.

GEN. LOVE: There is a real place for the Corps Area Laboratory to take care of certain specialized work.

COL. HILLMAN: There are 118 stations with hospitals of less than 250 beds, and no full-time laboratory officer.

GEN. MAGEE: The use of the Corps Area Laboratory as a central laboratory for small Corps Area stations would be of great assistance.

COL. HILLMAN: It appears to me that our laboratory work has generally run down a bit throughout the Army. Attention should be given to our laboratory service in order not to have men who are not qualified doing serological tests. As time goes on, hospitals will be developed in the Corps Areas of sufficient size to warrant the services of a full-time laboratory officer. This office should be notified of needs so that we can advise the Army Medical Center to fill requisitions for antigens. The Corps Surgeons will keep their smaller hospitals advised of places to which they are to send their serological work to be done.

QUESTION: W.D. Policy as to dispensary care and hospitalization of dependents (Medical and Dental).

GEN. MAGEE: Of course that question arises more frequently in Washington than anywhere else. It is a real problem. After talking with General Metcalfe, we agreed that just as long as we can do it with grace, we will continue to give help to dependents. But it appears now to be getting to a place where we will have to take some action because the Congress has not appropriated money for this purpose. If it is started at all, there will have to be a complete clearance. With Reserve and National Guard men coming in, it will be impossible to take care of such a number. The only solution appears to be to stop all hospitalization of this nature. It does not seem possible to discriminate between members of the Reserve,

the National Guard, and Regular Army. This matter will be discussed with the Chief of Staff and a policy arrived at as soon as practicable.

(At this point, Dr. Mountain, of the U. S. Public Health Service, spoke briefly on cooperation between the Public Health Service and the Medical Department. He stated that a man from the P.H.S. would be assigned as liaison officer in each Corps Area, and as individual problems arose they would be called to his attention, this liaison officer to act in such capacities as might be designated by the Corps Surgeon.)

QUESTION: Will social diseases be cause for deferment?

This matter is covered by S.S. Regulations.

QUESTION: Sanitation - Disposal of trash, putrescent and non-putrescent waste. If garbage sold, will it be sterilized and who will do it?

GEN. MAGEE: That is a question that must be answered in each Corps Area. I believe we all know the principles of sanitation and public health, and are all competent to take care of the problem. State laws will be complied with in the disposal of garbage.

QUESTION: Venereal prophylaxis and Public Health cooperation (covered by W. D. directive). Extent of isolation of venereals.

COL. HILLMAN: Venereal cases should be hospitalized instead of treated on duty status. Each camp should have a competent man to handle these cases, because it is really a matter for a specialist. We should follow the same rules we have always followed in the degree of isolation of venereal cases.

QUESTION: Floor space in tents. What is desirable limit of number of men in tents?

It was agreed that the desirable arrangement would include not more than 5 men to a tent, and only 4 if possible. This matter is covered by AR 40-205. It was suggested that facts relating to these conditions should be included in the Sanitary Reports.

QUESTION: Standard method of mess kit sterilization.

This question is treated in AR 40-205.

GEN. MAGEE: This matter will be taken up with the Assistant Chief of Staff, G-4, with a view to improvement of methods of mess kit sterilization.

FINANCE AND SUPPLY DIVISION

Finance:

QUESTION: Additional C. & R.H. Funds required by C.S.O....8th C.A.

COL. HALL: That opens up rather considerable question, about which Col. Tyng and I have been in conference, and in which we have a concurrence about the use of funds. For the convenience of everyone I have prepared a mimeographed slip which I would like to distribute to each officer. Of course all of you are familiar with C. & R.H. funds---how they are obtained, how they are distributed,--and with the establishment of all these new hospitals we are going to have quite a large amount of money to handle. We have been able to obtain a considerable amount, enough, I hope. It is important that no errors in its distribution or expenditure be made. A good many requests have already come in for C. & R.H. funds for expenditures that do not properly belong to the Medical Department but to the Building and Quarters fund of the Quartermaster. In column 1 you will notice that I have listed all employees that all our large hospitals will have to have, and those ought to be put not in C.& R.H. but B. & Q. Column 2 indicates those people who should be paid from C.& R.H. Colonel Tyng's department has taken over some of the others---fire fighters, engineers, boiler-makers, steam-fitters, etc. All those large hospitals are going to have fire fighters, as well as engineers, and these should be B. & Q. Boilermakers and steam-fitters normally are Quartermaster employees and should be paid from his rolls. In our large hospitals we do have some steam-fitters who work on lines; those might properly be C. & R.H. employees. The plumbers who work on equipment within the hospitals, of course, are C. & R.H., whether they are Quartermaster men just sent up there for a few hours' work or whether they are full-time employees. Sewage plant operators, on the other hand, are paid from B. & Q., Quartermaster activity, even though it is a sewage plant which serves the hospital only. These are defenses that have been made by the Quartermaster before Congress. We are just taking what has been done in the past as a guide. Utility clerks---in our large general hospitals we have had authorization, and even defended before Congress, a clerk paid from C. & R.H. funds who looked after utility records. I rather think that that's a little bit of a far cry, but we have spent C. & R.H. money for that. Many of our hospitals have an electrical shop. Electricians who normally work on house lines spend many days in the shop working on electrical equipment which is Medical Department equipment, and may be paid from C. & R.H. funds. Colonel Tyng, naturally, would have to give authorization for such an employee. We agreed that a thousand or two thousand bed hospital would have two electricians. We decided the C. & R.H. should pay for the first one, and the second---an assistant---would be paid from the M. & H.D. This division of funds can be applied to the payment of other employees. We have sufficient funds to establish those hospitals and set them up in housekeeping. We are in a position to make distribution of C. & R.H. funds through the Corps Area Surgeons for the hospitals that are under their charge.

COL. WEED: We probably will make use of barracks for hospitals. This might lead to confusion.

COL. HALL: Do not make this mistake. They say "All right, you can take barracks here and make a hospital of it." Then they begin to expend C.&R.H. money to do that. The agreement between the Staff, Quartermaster, and Medical Department was that we would not put in for money to convert barracks nor to build new hospitals. That would be paid from the Emergency Building Fund.

COL. BAYLIS: Who will initiate the request for additional C.&R.H. funds for the Corps?

COL. HALL: We will try to anticipate that, of course, in making distribution, but the thing is so nebulous now that I couldn't make allotments to the Corps Areas. For instance, Colonel Baylis, you are going to get four or five times as much as some other Corps Areas.

COL. McCORMACK: Is there any distinction between C.&R.H. for present installations and that which is to be used for cantonment-type installations?

COL. HALL: No, sir. Unfortunately, I know no other way. It's necessary for us to conserve these funds considerably. I can't visualize our civilian personnel employ. I have used the factor of sixty cents per man, but I don't know whether that is enough. We have to be careful in the establishment of these hospitals; we might have to pinch pennies considerably.

COL. BAYLIS: From what source should the funds come for the establishment of prophylactic stations out of the post?

COL. HALL: Your equipment should come from Colonel Tyng. The building that you have rented I have to pay for out of C.&R.H. The modifications in that building, unless you can have them done by the renter, we have to pay for also.

COL. GIBNER: In time of peace, at the larger station hospitals ordinarily barracks for enlisted personnel and your nurses quarters are maintained out of B.&Q., whereas the ward and clinical buildings are paid from C.&R.H. Will that hold in the cantonment hospitals?

COL. HALL: Theoretically, yes, but as a matter of fact, your quarters for nurses and for officers are considered generally part of the hospital, and that question has never arisen. I rather suspect that minor maintenance problems will be cared for from C.&R.H. Now, as for mess: the officers' mess, even in a 50-bed hospital, the equipment is put in and charged by the Quartermaster. The patients' mess is furnished by C.&R.H. and Colonel Tyng.

COL. McIRE: The question came up yesterday about the accommodations for civilian employees, both male and female, in these more or less isolated camps. Some provisions will have to be made for shelter. Who provides that shelter and who will maintain it?

COL. HALL: There is no provision anywhere in the scheme of things and no money.

GEN. MAGEE: This matter has been brought to the attention of the War Department. When these camp hospitals are built, they are built with barrack space for enough men to operate the hospital. Civilian employees are there in lieu of these men. So the only shelter we have would be where we have shelter available in the same proportion as prepared for enlisted men. The difficulty will arise about housing women. If one of the barracks is situated in a remote part of the post, that will be suitable for the women.

COL. HART: I think one solution to these isolated camp cases may be to use an increased amount of your civilian personnel at the larger hospitals; for instance, we could use more civilian personnel at Fort Sam Houston and take the enlisted personnel from there to places where no civilian personnel is available, and that will take care of the isolated stations.

While Colonel Hall is here, I'd like to go back to the hospital for the insane. Would it not be feasible to have somewhere in the central part of the United States a hospital for the insane, to which we could all evacuate? You've got to transfer them, and it seems to me that one central hospital would be economical of personnel, which is an important proposition because we haven't enough to man all these various little units.

COL. BAYLIS: As a suggestion, I had thought along that line, that a large proportion of the beds in these general hospitals be constructed in view of taking care of mental cases. It seems to me we ought to consider the question of whether we are going to hold on to these men indefinitely, or should they be turned over to the Veteran's Administration. If we are, then Colonel Hart's idea would be logical. Wouldn't the proper objective be, from our standpoint, to get these men out of the Army as soon as possible?

GEN. LOVE: That's true, Colonel Baylis, but we can't do it.

COL. REDDY: They will eventually come to the Veteran's Administration anyhow.

GEN. LOVE: The Veteran's Administration have already signified that they will relieve us of the care of chronically disabled men as rapidly as possible but under the present law they can not assume the care of these patients until they have had six months service. We will get a number of cases who have had less than six months service.

GEN. SNYDER: I think Congress will change the law.

GEN. MAGEE: It means then that every insane man is a Veteran's Administration case.

QUESTION: Procurement Authority for local purchases necessary during induction of National Guard?.....1st C.A.

COL. TYNG: This question was raised by the 1st Corps Area, and we sent you a procurement authority under which these bills could be paid.

I would like to have you gentlemen make a note of what I am going to say now. For the purpose of trying to segregate our accounts between what we spend on the National Guard and what we will spend on the Trainees, we have set up to each Corps Area for the National Guard the General Procurement Authority MD 799 P 99. Now gentlemen, P99 is an all-purpose number, by which you can obtain anything you require. We have never given P99 to the field before.

COL.PILLSBURY: What emergencies does this authority cover?

COL. TYNG: There are many emergencies that arise in which you would pay a dental bill, for instance, which has been paid by some line officer out of unit funds. Where a case comes to your attention, that a man needs dental treatment or that he needs hospitalization or any other medical service, those vouchers should be made out and sent to you and you may pay for those services from this Procurement Authority; but we recommend that inasmuch as you may have inexperienced personnel who will improperly make the vouchers, making it difficult to get them through the General Accounting Office, that these vouchers be sent to the Surgeon General's office for clearance, just as where services are procured from civilian sources and these vouchers are sent in here. Assume that it is necessary for you to obtain quickly medication on prescription. You may use this purpose number for the National Guard. The question is raised - could this purpose number MD 799 P99 be utilized for the procurement of Fehling's Solution? The answer is yes. I believe Colonel Pillsbury asked, "Could we employ typists for the induction of the National Guard?". The answer is no, inasmuch as that is a function of the Adjutant General to provide the necessary typists for that induction.

COL. GIBSON: That applies only to the induction of the National Guard and not to the training of the National Guard Staff.

COL. TYNG: Correct.

COL. GIBNER: Then that can be used for anything medical.

COL. TYNG: Generally speaking the functions of supply for the National Guard will not be usurped by the Corps Area Surgeons using this purpose number, but for all legitimate emergencies we certainly want you to use it. Now with reference to the induction of the Selective Service men, you will get a purpose number, MD800 P99, and for all expenses such as the pay of doctors, dentists, technicians, clerks, emergency supplies in connection with the boards, such as additional laboratory solutions and such other supplies as are within reason. Medicines on prescription will be paid for from the purpose number just cited, MD800 P99. We would appreciate very much your keeping these two separate in order that we may

make a proper accounting of the cost of the induction of the National Guard and the selection of trainees.

COL. GIBNER: This last would cover induction stations?

COL. TYNG: We would prefer that those be vouchered in here and we will take care of the purpose number, but should it become necessary for you to pay a bill promptly don't hesitate to use the number with the explanation as to why it was necessary.

QUESTION: Do doctor bills come out of this too?

COL. TYNG: If necessary. We prefer that all doctor and dental bills be vouchered into this office for the reason that our trained personnel can prepare the vouchers going forward in a way that will pass the General Accounting Office, and we suspect that your personnel may not be able to do so.

QUESTION UNDER PROFESSIONAL SERVICE WAS DISCUSSED FURTHER AT THIS POINT

GEN. LOVE: The question came up yesterday afternoon and General Magee suggested we ask you to give us some information on the standard method of mess kit sterilization. What provisions are being made in the temporary barracks under construction to provide for the cleaning and sterilization of mess kits?

COL. HALL: I have no information. My understanding was that the standard kitchen was being provided, and my impression was the mess kits would not be used.

COL. PILLSBURY: Anyway what about the sterilization of eating utensils?

COL. HALL: Just a standard sink dish washing facility is all that is provided in these kitchens.

COL. PILLSBURY: No provision at all for sterilization?

GEN. LOVE: What about our enlisted men?

COL. HALL: In our hospitals up to 500 beds, our men mess with the patients, and we have dishwashing machines and they use dishes.

QUESTION: Will Depot Credit Allowance for expendable supplies be continued? If so, should requisitions be held pending authorization of increases.....6th C.A.

COL. TYNG: We are going to abolish depot credits for standard items immediately. That will answer that question. I would like to ask this question: What about non-standard supplies in the period of the emergency? It is a very large project with us. There are many items that we must procure for the care of the sick which are non-standard but the vast majority of the non-standard items we are buying are those items which are the

whims of professional people. We hope that you gentlemen feel as we feel about it, that in a time of emergency non-standard supplies ought to be kept at a minimum and that all non-standard requisitions coming to your office should be scrutinized most carefully and blue-penciled most liberally. We don't want to take the position here that there shall be no non-standard supplies.

GEN. MAGEE: But if it is a satisfactory article it may be purchased?

COL. TYNG: We believe it would reduce our work materially if you gentlemen are agreed to this. We would like to establish non-standard credits. We feel that you gentlemen cannot give this the personal attention it deserves most, and you depend on M.A.C. officers who, by their very training, are not competent to judge when a non-standard product should be approved or disapproved.

GEN. MAGEE: Well, if you propose to establish credits for non-standard items, how would the matter be handled?

COL. TYNG: What we want to do is to avoid the delay in coming into this office.

COL. BAYLIS: That's with the understanding that we exercise rigid control?

COL. TYNG: We believe you will exercise that control in exchange for the increased speed.

GEN. MAGEE: Will that be satisfactory then--not give it a fixed credit but leave it to your discretion?

COL. TYNG: We would ask one other thing: That when your inspectors are going around (I am talking now primarily of your new installations) that they be cautioned to keep a weather-eye on the storerooms to see that an undue amount of articles does not accumulate.

SUPPLY:

QUESTION: Requisitions from Stations that have no Depot Credits for expendable supplies and requisitions now forwarded to S.G.O. causing delay .....8th C.A.

THIS QUESTION HAS BEEN ANSWERED BY PREVIOUS DISCUSSION.

QUESTION: Administrative ambulances required.....8th C.A.

GEN. MAGEE: There is no hope of getting any more ambulances before January 1st.

COL. TYNG: There will be available this fiscal year a total of 336 field ambulances and 72 metropolitan ambulances and we believe we are going to

buy that new type of the Navy. We have on hand of the field 274, 5 metropolitan and will require an additional 336 field and 72 metropolitan ambulances. These are all administrative ambulances. I don't know whether you gentlemen have seen the Adjutant General's letter of October 17, which places all ambulances, both tactical and administrative, in a corps pool under the command of the Corps Commander. They can then be distributed where they are needed.

COL. McCORMACK: We have in our corps area (9th Corps) 60 CCC ambulances, many of which have been in cold storage for 5 years. About 2 weeks ago we radioed the War Department for authority to transfer 30 of those to the Army. Nothing was heard from them. On October 9 we radioed again but have still heard nothing.

GEN. MAGEE: A question arises about ambulances. How many tactical ambulances do we have?

MAJOR GRIFFIN: We have 1150 tactical ambulances. There is a total of 887 that go to Regular Army Units and 250 to National Guard Units.

GEN. MAGEE: You will have your tactical ambulances before your administrative. I understand that the first delivery of ambulances we get will be those tactical ambulances now on order.

QUESTION: Requisition of equipment - Should they be based on normal size plus additional expansion or on basis of bed size and what differentiation in equipment between 1,000 bed Station Hospital and 1,000 bed General Hospital? When should requisitions be submitted? What is time lag?..... 4th and 7th C.A.

COL. TYNG: We are packing the following type hospitals which are complete with X-ray laboratory, mess and other facilities. Nurses' furniture should be requisitioned separately, because we don't know how many nurses you are going to have. The following hospitals are being packed: 25 bed, 50 bed, 100 bed, 250 bed, 500 bed, 750 bed and 1,000 bed. There are companion expansion units for each one of those I have mentioned except 750 bed. We are not packing a 750 bed with an expansion unit. The expansion units are nothing but housekeeping arrangements for your wards. They will have all the ward equipment so far as we can forsee it. They will have additional messing equipment to supplement any existing unit for which you require an expansion unit.

Please discourage anybody from putting in an itemized requisition for a 1,000 bed hospital. The equipment of these 1,000 bed hospitals is identical whether it is station or general.

GEN. MAGEE: The only difference in them would probably be a more expert personnel in our general hospitals.

COL. TYNG: Now the question is asked, "When should requisitions be submitted?". The answer is, submit them at once if you know what you are

going to need, but in any case submit them just as soon as you know your needs and state at which time you desire the hospital delivery. We hope that there won't be any time lag if we can get sufficient notice as to when you want your hospitals. We do hope that you will impress upon your supply officers the necessity for keeping some supplies ahead without loading up the shelves. Here in the states we think you should have a minimum of 6 month's supply and 3 month's supply of deteriorating articles.

QUESTION: How will transportation be furnished? What will it include? When will it become available?.....7th C.A.

GEN. MAGEE: That's motor transportation for the hospitals.

COL. TYNG: A question was asked as to how much supply these hospitals would bring with them. Normally 90 days.

QUESTION: Can supply of items to complete shortages of medical equipment of National Guard Units be expedited and furnished before departure from C.A. of origin?.....1st C.A.

COL. TYNG: Do you mean, Colonel Reddy, after they have been inducted?

COL. REDDY: Yes sir.

COL. McCORNACK: They were ordered to go to camp with 2 month's supply of every kind.

COL. GIBNER: How about control items?

COL. TYNG: Normally we expect to have those requisitions come in here, so we can clear them to the particular depot which has them packed.

COL. McCORNACK: Should kits be issued instead of belts?

COL. TYNG: The Medical Department should be issued kits instead of belts to replace the old belts.

QUESTION: Lack of supplies and storage space.....9th C.A.

COL. TYNG: You realize, of course, that I have a great many items packed, but cannot ship them because of the lack of storage space at the various posts. It is suggested you requisition equipment and supplies as soon as you have a place to store them, even though you are not yet ready to use them.

QUESTION: Can a central supply depot for neighborhood units be used?... 4th C.A.

COL. TYNG: The answer is yes.

COL. McCORNACK: With all the civilian personnel and clerks required,

there is going to be a tremendous demand for typewriters. Where are we going to get them?

COL. TYNG: The hospitals come equipped with typewriters. If you do not have enough, put in a requisition to this office. We are prepared to furnish you all you need.

CIVILIAN PERSONNEL (Field):

QUESTION: Civilian Employees - Is the allowance of S.G.O. cumulative; i.e., can vacancies not filled by a certain date be filled at a later date?.....7th C.A.

QUESTION: Is the allowance of Surgeon General's Office of civilian employees cumulative?

COL. TYNG: It is.

QUESTION: Can vacancies not filled by a certain date be filled at a later date?

COL. TYNG: They can.

Suppose you have a civilian, and you lose your Sergeant Major, and this civilian can be made use of. You may appoint him to a CAF 5, but when you hire that individual why not hire him as a CAF 3 in the beginning? Hire as many as you can in the lower grades, because under the formula of the Bureau of Budgets you cannot promote these people; you can only re-allocate them. Therefore, our recommendation is that you save these higher jobs as long as you can, so that you can make worthy promotions later. In appointing these people we wish you would follow the positions we have designated here absolutely.

There's just one more thing that I'd like to bring up. I'd like to bring this point to the attention of all you gentlemen, because it is highly important. We have put down here for you plumbers, electricians, engineers, and employees of that sort. You have all had difficulty getting them from your local Quartermaster. Go out and get them when you need them, but don't keep them more than 60 days.

QUESTION: What is per diem compensation for civilian physicians employed on examining teams and will the compensation be the same for general practitioners and specialists?.....1st and 3rd C.A.

ANSWERED BY PREVIOUS DISCUSSION.

COL. TYNG: About 1932 the operating surgeon on duty at Fort Warren reported more than 2 sudden deaths directly attributed to Mallincrodt ether. He said he would never use Mallincrodt ether again. We brought the matter immediately to the attention of the anesthetist in our office. We immediately went to the Controller General for permission to buy only Squibb's ether, which we obtained. Now the question has come up: If we found the

Squibb plant sabotaged, the supply would be cut off, so that we would be dependent on Mallincrodt ether. Can we consider Mallincrodt ether? From the standpoint of the Supply Division, the most careful analyses and from very excellent anesthetists, Mallincrodt has a clear record, just as clear as Squibb's. The reason for not using Mallincrodt was attributed to these deaths.

GEN. MAGEE: I know Colonel Keller refused absolutely to use it; but it seemed that was old ether.

COL. TYNG: Well, there was at one time a lot of bad ether that got out from the war stock. It was sold by the Veteran's Administration and got into the hands of unscrupulous dealers, but that was before they found that the presence of a very small amount of native copper will prevent the formation of deleterious aldehydes and other irritating substances. Squibb's coats the inside of cans with copper, and Mallincrodt puts a few grains of native copper into each can.

COL. HILLMAN: Well, my impression is that Mallincrodt ether is all right, but understand that is only an impression, as I am not doing surgical work and cannot give you the latest. I am sure it is accepted by the American Medical Association and the National Council of Medical Research. If so, it meets acceptable requirements.

COL. McCORNACK: My personal experience in 1910 and 1911 was the same; we did not use it for a while.

COL. GIBNER: Mallincrodt is extensively used in civil life, is it not?

COL. TYNG: Well, then, in event of sabotage of the only plant Squibb has, you may find Mallincrodt coming into your offices.

STATISTICAL DIVISION

QUESTION: Statistical and S.&W. Reports clarification of Radio stating "sick and wounded cards will show organization and identity of case for statistical study." Does it intend differentiation of R.A., N.G. Reserve and inducted force?.....8th C.A.

COL. MEEHAN: The reason the radio was sent out was to relieve the out stations from a lot of trouble. In other words, in time of peace they have to distinguish what the command is made of--Reserves on two weeks' duty, Reserves on extended duty, etc. We want to combine the whole business under the National Army, and the reason that particular thing was added was just explanatory.

QUESTION: N.G. Induction - Are Forms 40 required for enlisted men?..... 3rd C.A.

COL. McCORNACK: The 130-10 Army Regulation requires that Form 40 will be required for officers. It does not specifically say officers, but

that is included under the paragraph pertaining to officers. Under enlisted personnel a list of the forms made up does not include Form 40.

GEN. MAGEE: Apparently, then, Form 40 which we usually think of as applying to enlisted men really applies to officers, and is not required for enlisted men.

QUESTION: Will S.&W. Reports be checked by C.S.O.?.....4th and 6th C.A.

COL. MEEHAN: They ought to come through the Corps Area, because there are so many things the Corps Area can check quickly. As far as the cards are concerned, we will take care of that. Would it be feasible for us to deal direct with the hospitals rather than the Corps Area Surgeons?

GEN. MAGEE: Don't you think the Corps Area Surgeons should be advised?

COL. BAYLIS: I think it is necessary for them to go back through us. However, I don't want us to worry about line of duty, days lost, nomenclature, etc.

COL. MEEHAN: Line of duty, days lost, etc., will be checked by this office. The thing that gives us the most trouble on these are on the Form 51's in the change of unit. We keep an exact daily record of where all the units in the United States are. Form 51 can be checked more carefully by the Corps Area.

QUESTION: Any changes in L.O.D. determination.....4th C.A.

COL. MEEHAN: The only change in L.O.D. that will come in is in case of accidents. This is an administrative thing and is up to the local boards. The surgeon does not have to worry about it at all.

COL. McCORMACK: On that thing, in my Corps Area, I have given instructions that no boards are to be called unless the post surgeon certifies in writing that in his opinion the accident is liable to cause disability in the future.

QUESTION: S.&W. Reports and Statistical Reports too intricate and checking too rigid.....6th C.A.

COL. MEEHAN: What we want to do--they have changed some statistical reports, too. Of course, it won't fit the present situation, but the principal thing on that where we tried to reduce a lot of confusion was in separating them. Now they will only report on the statistical as though everybody was in the Army, except, of course, you will have to show CCC-occupied beds, but everybody else is in the Army. Now what are you referring to--all the designations under infectious diseases?

COL. GIBSON: It is not adaptable for our Army today. It doesn't apply to troops as we have them organized today. It is not clearly defined on the instructions.

COL. MEEHAN: New regulations will cover it. The new form coming out is changed a little, and I think the instructions on this are pretty clear.

The Adjutant General is going to set up a complete apparatus at Corps Area Headquarters to show the change of status of every man in the place. They are going to operate in the Corps Area Headquarters rather than the Army Headquarters.

GEN. MAGEE: Shall we make a station report, that is, have a statistical report rendered by the Station Surgeon for all elements in his command, and the only departure from that would be when troops went out on maneuvers?

REFERENCE BACK TO QUESTION - PROFESSIONAL SERVICE DIVISION.

COLONEL HALL: Each camp has an incinerator. It will be a big one, large enough to handle the garbage. Steam will be available for sterilization of garbage cans at each incinerator. Dish washing machines are in all cafeterias for line use where they have over 500 men. Dish-washing machines are in all hospital messes of over a hundred. The usual line mess runs from 175 to 250 men, and they have only the usual dish-washing sinks. Dishes are being issued to all fixed messes, even in tent camps, so they will not use their mess tins. The nurses' quarters and officers' quarters in hospitals, if general hospitals--I will keep those up from C.&R.H. funds; in the station hospitals, the money will come from B.&Q.

DENTAL DIVISION

QUESTION: Dental service - Physical setup. Class of work to be done and locations of dispensaries and laboratories.....4th C.A.

GENERAL FAIRBANKS: We have just recently provided from the office a list submitted to the Adjutant General for orders assigning Corps Area Dental Officers. That was taken up through the office and we agreed it would be the best policy to assign them to the corps areas which are particularly active. It was sent forward to the Adjutant General but he sent it back and told us to name one for each corps area. That has already been accomplished and their orders should be out within the next few days. The regulations state that in war-time that would be necessary and also state that it may be in peace-time. Inasmuch as an emergency exists at the present time which creates a situation of many dental problems, it was taken up in the office and sent to the Adjutant General. It was over to the War Department but came back asking us to name them. Then G-1 called up and they set up the corps area overhead and they added that one extra dental officer to the corps area overhead of dental officers. It is anticipated that those officers could be of material assistance to the corps area surgeons as their problems increase. The personnel has already

been set up in G-1. In the matter of supply the office has made plans for all the different types of equipment that are necessary for our various mobilization installations. We hear so much today about the various types of clinics, I have not felt at all that this office should say anything about what should go into a camp; that is the prerogative of the corps area but we did establish what should be the basis of these various types of clinics. We have a 15 chair clinic which will be provided for the triangle division and also for camps of concentrations from 10,000 to 15,000. We also provide a 25 chair clinic for the square division and for troop concentrations of around 25,000. However, there are a lot of the camps which vary in size and it has been necessary to have 2 of these large camp clinics--Benning is one of these places and Fort Jackson is another. As we bring in the various reserves and National Guard dental officers on the basis of a training program, it is not anticipated that any of these men will have had experience as to handling property, etc. That is what they must get in their training program.

We are able to provide enough senior dental officers who can be assigned as camp dental surgeons as the assignment is made of camp surgeons, and they can help swing this dental picture. As our Reserve and National Guard come into this training program they will have senior dental officers to carry out the program. In these large clinics it is necessary that we have men who are qualified for heading the various activities. For that purpose we have a general hospital training program in which we are setting up training facilities at each of our general hospitals to turn out reserve officers who will get training along certain lines. For instance, it is absolutely necessary to have a man in each clinic who will be chief clinician. The allocation of work must necessarily be made in the clinic itself. The course of instruction will be given to selected men.

We also have a proposition of dental replacement. We need men trained in prosthetic service. In that service we have set up our standards; we have furnished the facilities to supply them. It has to be done our way in order to make that effective. We also have training for enlisted men to fit in with this picture--mechanics, x-ray technicians, and in some instances, hygienists, but in the main, our big problem with this Army as it comes into existence is going to be the matter of required replacements which we are going to keep at a minimum. At the same time we appreciate the fact brought out in our discussion with Colonel Hillman yesterday that we are going to meet up with some problems. In a number of these dental clinics in the camps we will establish large laboratories. Some years ago we established our central dental laboratories. They are marvelously equipped outfits and they have increased the dental service way beyond our expectation. They can carry the load up to a certain extent, but it was agreed in the office that it would be a mistake for us to increase our central dental laboratories on the scale we originally planned because they were expensive. It cost us about $300,000 to install one of those central dental laboratories. We have, however, planned that in these large general hospitals which we will establish, the hospital subdivision will provide laboratory service of such size that it will be able

to serve the stations in its vicinity. The only thing is that we are not going to make any plan to extend our laboratory service for troops beyond that of which we can anticipate a reasonable normal function of the individual. For instance, if a man has been able to get along in civil life without having his mouth put in Class 4 condition, we are not going to do that for him. On the other hand, if a man loses a lot of teeth in line of duty we will have to do something for him. Our idea is that we are going to hold pretty close for this draft army to the ideas of the CCC. If something occurs in the line of duty and the man loses teeth, they will be replaced.

There does come a big matter of training within the divisions of these camps themselves. The problem has come up relative to the corps area service command that in tactical units, the matter of superimposing an army in the theater of operations on top of the zone of the interior. It is a matter of getting training to as many of our medical officers as we can. I am sure that the corps surgeons can see this picture and will desire some real effort along that line, since our officers in the tactical divisions are going to get pretty tired of it if they have to stay there a year. At the same time, with our dental officers, I think all those in the divisions should learn to be medical department officers, and I believe it would be desirable to have a training program to make that effective. During a certain period of time they will learn what their field equipment is, etc. If we can do that for a period of 3 to 4 months, we can make them very efficient officers. Then it would be most desirable if they could be transferred to camp dental clinics but there comes a problem relative to the corps area service command on one hand and the Army control on the other.

COL. GIBSON: For instance, in an exempted station there is a clinic in the station hospital containing two or three chairs. Those dentists are to care for the patients in the hospital. Are the people operating this clinic to come from camp overhead?

GEN. FAIRBANK: They are to come from the corps area service command supplemented by people from the division. We can't carry on a training program any other way because you will be dragging those men out of the clinic where they must give definitive treatment. In the division itself the regimental surgeon will be taking sick call in the morning and the dental officer can hold his dental sick call at the same time but when it comes to definitive treatment the place for the men to get that is in the camp dental clinic.

In the triangle or Regular Army division there are 13 dental officers. In the square or National Guard Division there are 21, in the armored division there are 17. Overhead is figured 1.5 dental officers per thousand for troops but in the combat organization .5 per thousand; so that would make a total of 2 per thousand. The split won't work exactly that way under these new tables of organization. If we can rotate dental officers from tactical units to camp clinics and hospitals we will put over a training program which will let the men know what it

is all about. Within these tactical units the trainees will know what field dental service is; they also have training as auxiliary medical officers.

As to supply, authority is available, so Colonel Tyng tells me, to the corps area surgeon in the exchange of new equipment for old. We are buying great quantities of new equipment and where it is desirable, in our permanent installations, we are going to put on a big program for war and our permanent installations will be neglected. Where it is desirable to change to new equipment--chairs, cabinets, etc., for our operating room--it's all right for an exchange of that property between these offices and the depots. The corps surgeons can authorize that and we can put the older equipment in the camps.

NURSING DIVISION

QUESTION: Responsibility of C.S. in assignment of nurses to exempted stations.....8th C.A.

SUPT.-FLIKKE: We won't be able to furnish many. We have only a quota of 1100 in the Regular Corps, and we don't get any of the reserve nurses. They have to come through the corps area.

COL. HART: What is our responsibility toward reserve nurses up to the quota?

SUPT.-FLIKKE: We would like to have Army nurses heading every station, of course, and we expect to do that. We have been asked by the 4th Corps Area to send nurses to Camp Shelby and Beauregard and we are sending 1 Chief Nurse and 4 assistants. We have set up a number that we think should go to each of the hospitals. We expect to have 8 to 10 Regular Army nurses for a 1000 bed hospital.

COL. GIBNER: You expect to have 8 to 10 Regular Army Nurses for a 1000 bed hospital. Do you want us to write in to this office and state we are ready for the assignment of the Regular Army nurses?

SUPT.-FLIKKE: We would like to know which hospitals are going to open up and whether there are places for quarters for them. The corps area surgeon will be informed by the office of the Surgeon General the number of regular nurses to be assigned and the number of Reserve Nurses required. The Reserve Nurses required will be procured and assigned by the corps area surgeon.

QUESTION: How does a nurse get on the reserve list?

SUPT.-FLIKKE: I think all she has to do is to apply to her local chapter of the Red Cross and give her qualifications, or if this is not possible she should correspond with the National Headquarters of the Red Cross. She first has to enroll as a Red Cross nurse before she can come into the Reserve.

COL. PILLSBURY: About how long does it take after applying to get her name enrolled?

SUPT.-FLIKKE: That all depends on the local chapter. We may be able to speed them up a little. We have had that trouble quite often.

QUESTION: What procedure will be followed if there is an insufficient number of Reserve Nurses to meet the demand in the C.A.? Can civilian nurses be hired on a civilian status?.....1st C.A.

SUPT.-FLIKKE: In that question, if there are certain places where there is an insufficient number, isn't it possible there may be a surplus in other corps areas? If these names are sent to us could we not assign them?

ANSWER: Yes. Civilian nurses can be hired on a civilian status for a period of not more than 60 days.

QUESTION: Chief Nurse and Assistant Chief Nurses for Z of I Hospital. What will be grade and source?.....3rd C.A.

THIS QUESTION HAS BEEN ANSWERED BY PREVIOUS DISCUSSION.

SUPT.-FLIKKE: It has been our plan to send one nurse to each corps area headquarters if they are wanted.

QUESTION: How many assistant superintendents have been authorized?

SUPT.-FLIKKE: 10 have been authorized, but they are to go to the 2000 bed hospitals. I feel that it would be very much more important to take care of a hospital of that size than to take care of the work in an office.

COL. BAYLIS: But I am depending on the nurse assigned to corps area headquarters to run the nursing service for me and I would prefer an assistant superintendent.

SUPT.-FLIKKE: Very well, assistant superintendents will be assigned to the corps area headquarters.

QUESTION: Nursing service--Procurement allotment. Proportion to patient beds and percentage of Regular and Reserve.....4th C.A.

COL. BAYLIS: How large should a post camp or station be before we are justified in considering the assignment of nurses?

COL. GIBNER: No matter how small a hospital is you can't run it with less than 4 nurses.

SUPT.-FLIKKE: 5 nurses is the minimum. The proportion to patient beds is 1 nurse to 8 to 10 patient beds.

VETERINARY DIVISION

COL. KELSER: With the expansion of the Army the Veterinary Service initially was interested primarily with food inspection and that became a question largely of personnel rather than installation. That was taken care of with the authority granted to bring in reserve officers on extended active duty. Lately, however, there has been a move made to increase the animal population of the Army, over and above the 7,000 and some odd number of horses and mules authorized for purchase July 1st. The last Army bill signed by the President carried authority for the procurement of approximately 20,000 more. Of that number approximately 11,000 are to be obtained, half by November 20 and the other half by December 20, according to the Quartermaster General's Office. That has raised the problem of increasing veterinary hospital installation, and initially it will be at the remount depots where these animals will go and as they are individual stations that has been a matter being handled between the Surgeon General's Office and the Remount Branch of the Quartermaster Corps. The question later, however, will be one that will involve the expansion of some of the facilities as these animals go out from the depots. We know, for instance, at Fort Jackson there will be a number of animals and steps have been taken to provide veterinary facilities. At Fort Riley there will be a cavalry replacement unit and there will be some 3,000 additional animals sent there, and that will mean an increase. There again you have an increase in which the corps areas probably won't be very much concerned. For the past several years we have worked in this office on the development of plans to provide veterinary hospital facilities, not knowing how many animals would be used or where they would be used. As a result, those plans took the form of units. In other words, a veterinary surgery clinic and barracks buildings, etc., and we can build up from these units any size of installation that might be required. At the present time we have been getting in from different stations where it has been indicated the animal strength will be increased a conglomeration of plans recommended locally, and in each case it has been necessary to call attention to the fact that we already have this set up. This will be temporary construction; all we have to know is the number of animals and the area available.

I might mention a few things regarding the training in connection with our Food Inspection Service plans on the way to take care of the training of relatively small classes of Veterinary Reserve Officers of Chicago. That's the best place we have for the training of reserve officers in conjunction with food inspection, especially in the preparation of canned food products. Probably we will be able to handle about 20 in a class. All those training classes will probably run about a month.

For mounted service we have been sending in a surplus of officers to Fort Bliss for training with the 1st Cavalry Division, as they can handle them. The same at Fort Sill with the Field Artillery Units. As you know the Quartermaster General has the country split up into 7 remount areas. Each of those areas has a remount purchasing and

grading headquarters. With the Laboratory Service we have arranged to assign for a 3 months course, at the present time, reserve officers who already have special training and experience in laboratory procedures. They are sent to the Army Veterinary School where an intensive type of training to especially fit them for laboratory test procedures.

With regard to veterinary supplies and equipment, of course, the general veterinary supplies and equipment are covered by the medical supply catalog and it is indicated that pertains at present just as it has in the past for the ordinary run of supplies. The same procedure and the same method of obtaining non-standard supplies is carried out or has been prescribed for human facilities, likewise applies to the veterinary service. We have developed a veterinary dispensary equipment for field organization that is a series of chests and they will be as prescribed by the tables of organization.

The question within the past two months in allotment of medical department reserve officers made to each of the corps areas for procurement and assignment by the corps area. Apparently that letter was not definitely clear because the quota was allotted and it was the intention that the officers would be procured and assigned as they were required, rather than to procure them immediately and put all of them on duty at once. There was no restriction; it was not intended that any corps area would be prevented from being a few officers ahead and training them for assignment but it was not the intention that the entire group be brought in immediately upon receipt of that directive and held waiting the organization of the units with which they were to serve. All of this training thing has been worked up and we don't want to duplicate any more than we have to. We are not going to raise any questions. We have done it ourselves by ordering a man to active duty at one of the depots before he goes to his station.

We can furnish a veterinarian for every division camp and will spread personnel as far as possible; reserve personnel will be supplied to corps areas to fill in.

MAJOR WAKEMAN: (DISCUSSION OF TRAINING). As far as the training subdivision is concerned, there are only two methods of training--the formal and the informal. To relieve the stations and units of some of their responsibility, we recommended about four months ago that medical enlisted replacement centers be established to train Medical Department personnel. That could not be, because there were no funds available until after the passage of the Selective Service Act, and appropriations were made. Enlisted replacement centers will be established and we will have our medical replacement centers after April, but prior to that time we must train by the informal or understudy method. All the trainees we receive prior to April will have to be assigned as fillers in existing stations. On February 10 we are going to activate 5 evacuation hospitals, 10 general, 5 surgical and 10 station at one-half their strength. They are to be trained adjacent to large general or station hospitals; they are

not a part of station or general hospital complements. They are additional trainees; they will be Selective Service men and will be trained with the idea of furnishing the cadre for a general hospital when activated. They will have a training complement of not less than 3 officers. We do not contemplate calling the officer complement of the numbered general hospitals or affiliated units. Those 3 officers will give that training and the practical training will have to be taken in the hospital as an understudy to the actual position. We don't favor that type of training; however, we have no choice in the matter. We would prefer to send all our Selective Service men and trainees to replacement centers for 13 weeks but we haven't the replacement centers and at the present time they have to be trained by dispersion. That means continued depletion of your training personnel. In other words, we have to keep on drawing out training enlisted cadres all the time. In reference to enlisted replacement centers, we have to have our officer personnel and our enlisted cadres for those centers. We have 2 for the Medical Department, one at Camp Lee and one at Camp Grant. There will be approximately 7,000 men in each one of these enlisted replacement centers. Instructors and enlisted men are to be on the job by February 15th. I have made a rough calculation of the personnel necessary to run one of these camps. I figure that it will be necessary to have 8 Regular Army Officers. The Surgeon General is responsible for furnishing that personnel, and also for 125 Reserve Officers and 800 to 900 enlisted men.

COL. BAYLIS: Who is going to supervise this training in camps?

MAJOR WAKEMAN: The corps area surgeons. Men are to be selected starting April 15. Specially qualified men will be selected from these replacement centers and you will be relieved of the responsibility for them; they will be taken to these 7 specialists centers, which have been set up. There they will receive 8 or 12 weeks of specialists' training.

Construction has been requested and all of it has been approved except that at Fort Sam Houston, which is awaiting action by the Commanding General of that corps. The construction at the Army Medical Center is necessarily semi-permanent and I did not include it in your list. The money for the equipment and supplies has been made available as soon as the budget distributes it.

QUESTION: What about training in civilian institutions?

MAJOR WAKEMAN: Well, the War Department still has a limitation of not more than 2% enlisted and officer personnel of the Regular Army on the basis of a 375,000 Army. I put those estimates in yesterday and I think they will be approved. I asked for 1,000 enlisted men to be trained at civilian institutions. These must be three year enlisted men, not inductees. There is a 13 weeks training program that has been set up for all Medical Department units.

GEN. LOVE: Can Corps Area Surgeons employ civilian nurses to supplement reserve nurses?

COL. TYNG: In the fiscal year 1941 you can supplement your Army nurses by civilian nurses; for a period of 60 days. You can get them without reference to your Civil Service branch but for anything over that, get them through Civil Service. As for 1942, I can't answer your question. I have no authority at this time.

GEN. LOVE: Are they authorized to substitute new dental equipment for old?

COL. TYNG: We have given quite a bit of thought upstairs as to how we could do this without disrupting things too much.

I have a letter from the 4th Corps Area which I would like General Snyder to answer. "Information is requested as to whether or not it is desired that National Guard Units inducted into the Federal Service will continue to use the old type of equipment during their year of training or whether it should be replaced by new field equipment". The individual equipment of the National Guard old style belts can be replaced by individual equipment, new style, upon request of the corps surgeons. It is requested that the equipment for medical regiments not be asked for at this time, until toward the end of the year when the old equipment can be modernized by new equipment now in the possession of the Medical Department but not yet packed.

COL. HILLMAN: The question was brought up this morning about Mallincrodt ether. I had a call from Dr. Graham who is chairman of the Surgical Committee of The National Research Council, and heads this committee of about 12 of the most prominent surgeons in the country. He said, "We all use it here in St. Louis. It is used all over the United States by civilian physicians and we hear no complaint about it. I would say that Mallincrodt ether is as good as Squibb's ether, but we will put it up to our committee on anesthesia and they will give us their opinion on it".

I just thought that it might warrant a few minutes' discussion of a new subdivision of food and nutrition that has been established in the office. As the tempo of preparedness increased in recent months, we had all kinds of inquiries from people of repute and otherwise about what the Army was doing on nutrition. Now it has been recognized that nutrition is a real problem. It has gained in importance in recent years and has been placed on a more scientific basis than ever before. General Magee felt that although the Army ration as prescribed in Army regulations is certainly an adequate ration, there is quite a difference between the ration that is prescribed in regulations and what the soldier gets to eat. It was felt that the subdivision of food and nutrition to give medical supervision to the Army mess was in order. The Surgeon General asked the War Department for authority to establish a subdivision of professional service. We are very fortunate in having in the sanitary corps Colonel Howe who is a nutrition expert.

COL. BAYLIS: How far have your plans been worked out?

COL. HOWE: There is a shortage of officers who have the kind of training necessary but I think there is a place for such men in your corps. The way Army rations are there is no way of knowing whether a man has an adequate diet except the ration. I think the experience in the last war shows that you can use a man of this kind. There are very few men in reserve that I would consider suitable. Their value depends on their background plus their knowledge of the Army and a good deal of common sense.

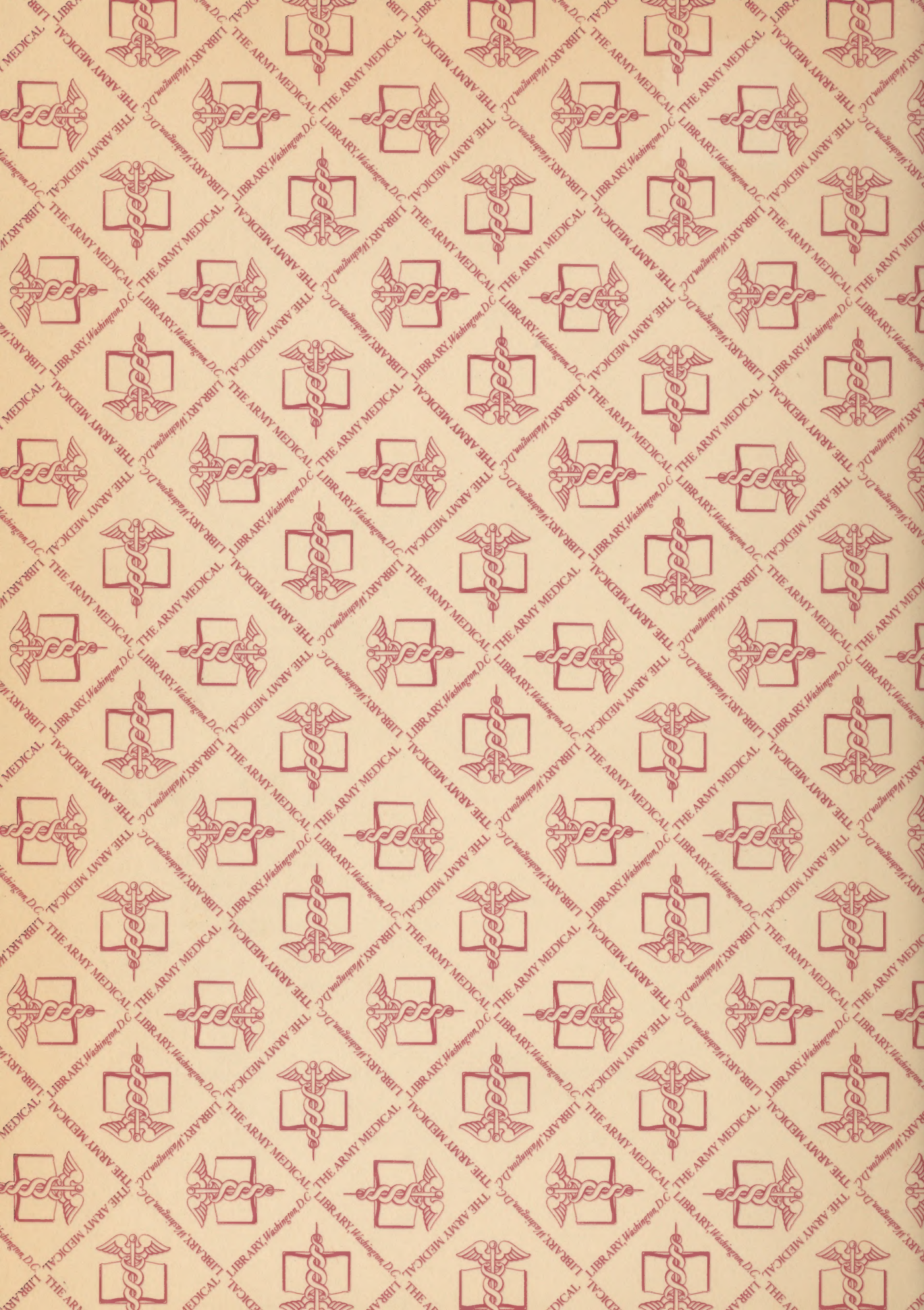
COL. GIBNER: Put a nutrition expert in the camp surgeon's office of each camp.

GEN. LOVE: Are you putting dental clinics in your plans for these cantonment hospitals?

COL. HALL: We have asked for them and I think we will get them but we have incorporated them in all the big hospitals recently designed. What we have recommended is this: After conference with General Love and General Fairbank we finally put up the proposal that we have central dental clinics. That has been agreed to. Central dental clinics of two sizes have been made--DC-1 that has 25 dental chairs, DC-2 that has 15 chairs. Recently, on my own initiative, I have put in one of these DC-2's at all our large hospitals. First to take care of the dental service of the hospital itself and second to give space where dental laboratory work for the surrounding dental clinics can be done. The laboratory building has been re-designed and came to you in plans that were sketched in. This is being authorized later. It is merely marked <u>proposed</u>.

COL. McAFEE: I have just one matter that I wanted the Surgeons to know about. That is the central hospital fund of about $180,000. Local funds are regarded on a share basis. When you transferred a cadre to a new organization, they took their part of that hospital fund with them. I believe Colonel Baylis set up $3 per head for new organizations and new tactical units. Now we are getting some requests to start the new installation hospital funds. They vary from $100 to $1500. In fact, one station hospital made a request for $4,000 and said they would send back what they didn't use. After we figured it out we sent them a thousand dollars and haven't heard from them since. They made available to the fund accounts receivable from the state dispersing officer for the hospitalization of National Guard personnel. We all appreciate that these funds accumulate mostly from the savings on patients, and in this way the funds are up materially.

A unit that has a chance to profit by a loan--they are really having a hard time getting along existing on their ration alone--it seems to me an outside donation there is all right, but with those other units in station hospitals that are coming in now, we'd like to loan them the money. The basis we put it on would be the size of the unit. Up to 25 beds-$200, 100 to 200 beds-$600, 750 to 1000 beds-$1000.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